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ABSTRACT

This paper describes the "Starting Early Starting Smart" (SESS) project, an early intervention program that has been developed in the context of the national, multi-site program and evaluation. The emphasis in SESS is on the integration of behavioral health services into easily accessible, non-threatening settings where caregivers naturally and regularly take their young children. Current SESS sites are based in primary pediatric health care and early childhood educational settings. The major goal of this early intervention service integration approach is to increase access and utilization of needed behavioral health services by families with young children, thereby improving child and family outcomes and resiliency. The focus is on providing and coordinating prevention and early intervention activities for young children as well as their adult caregivers and siblings to strengthen the entire family. Throughout these activities, SESS programs advocate a relationship-oriented approach at all systems levels, including parent-child, family-staff, staff-agency, and agency-agency interactions. The purpose of this paper is to assist policymakers and program administrators in replicating the SESS approach by describing its essential philosophical principles and structural components. In addition to the description of the SESS philosophy, a general overview of the implementation and planning processes is provided. (Contains 132 references and 4 exhibits.) (GCP)

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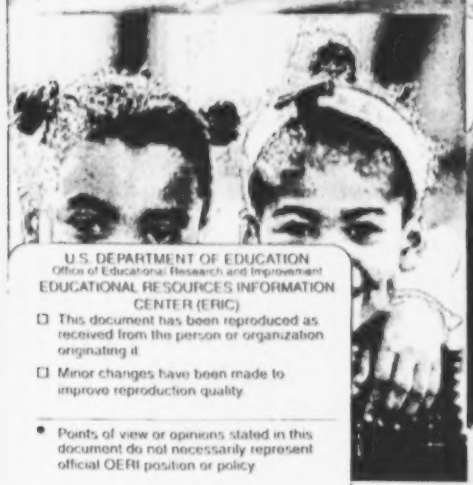

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Key Principles in Providing Integrated Behavioral Health Services for Young Children and Their Families:

The *Starting Early Starting Smart* Experience

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ABOUT STARTING EARLY STARTING SMART

Starting Early Starting Smart (SESS) is a knowledge development initiative designed to

- Create and test a new model for providing integrated behavioral health services (mental health and substance abuse prevention and treatment) for young children (birth to 7 years) and their families; and to
- Inform practitioners and policymakers of successful interventions and promising practices from the multi-year study, which lay a critical foundation for the positive growth and development of very young children.

In October 1997, with initial funding of $30 million, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Casey Family Programs embarked on a precedent-setting public/private collaboration. Twelve culturally diverse grantee organizations were selected. Each provides integrated behavioral health services in community-based early childhood settings—such as Child Care, Head Start and Primary Care Clinics—where young families customarily receive services for children. Critical to this project is the required collaboration among funders, grantees, consumers, and local site service providers. Implicit in the design of this project is sustainability planning for secured longevity of the programs.

The SESS approach informs policy-making for:

- Service system redesign
- Strengthening the home environment
- Using culture as a resource in planning services with families
- Service access and utilization strategies
- Targeting benefits for children
- Working with families from a strengths-based perspective

The Research Design

The 12 grantees, working collaboratively, designed a study whereby integrated behavioral health services are delivered in typical early childhood settings. Each site has an intervention and comparison group, and each site delivers similar targeted, culturally-relevant, interventions for young children and their families. A collaboratively determined set of outcomes has been established to evaluate project effectiveness:

- Access to and use of services
- Social, emotional, and cognitive outcomes for children
- Caregiver-child interaction outcomes
- Family functioning

The goal of the SESS research is to provide rigorous scientific evidence concerning whether children and families participating in SESS programs achieve better access to needed services and better social, emotional, cognitive, and behavioral health outcomes than do the children and families not receiving these services. SESS programs may also generate information about opportunities, practices, and barriers to sought-after outcomes. This information is critical to achieving effective public policies.

SESS Extended

It was clear from the early days of SESS that whatever effects were uncovered, longitudinal extension of the study would be valuable. In 2001, SAMHSA and Casey Family Programs embarked upon an extension phase, which will increase understanding of the impact of early intervention as young children enter preschool and school years, when babies or toddlers are asked to meet escalating emotional and cognitive demands. This longitudinal extension can validate early methods and findings and assess their durability. It is anticipated that this work will include additional data points of a refined instrument set and intervention package with the addition of study questions related to cost and value, and other special studies. Additional future plans include applying and validating early SESS lessons learned, key concepts, components, and principles to new settings that serve families with young children.

Summation

In sum, SESS reflects the growing acknowledgement that it is important to target positive interventions to very young children. The infant and preschool years lay a critical foundation for later growth and development. Second, successful interventions for very young children must meet the multiple behavioral health, physical health, and educational needs of families. Third, integrated behavioral health services must be made more accessible to families with multiple needs, which are difficult to meet in a fragmented service system.

For more information about *Starting Early Starting Smart* and related SAMHSA-Casey products, contact *www.casey.org* or *www.samhsa.gov* (SESS section under construction).

Key Principles in Providing Integrated Behavioral Health Services for Young Children and Their Families:

The *Starting Early Starting Smart* Experience

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CONTENTS

SESS Program Acknowledgments v
Executive Summary vii
I. Purpose and Program Overview 1
II. Philosophical Principles and Underpinnings 3
A. The SESS Philosophy 3
B. Cultural Competence 4
C. Service Integration 6
D. Potential SESS Settings 6
III. Implementing a SESS Program 7
A. Community Assessment 7
B. Family Involvement 8
C. Collaboration 9
D. Staff Support, Training, and Supervision 11
E. Recruitment and Retention of SESS Participants 11
F. Sustainability 12
IV. Building an Intervention Approach 13
A. Basic Foundations of Integrated Behavioral Health Services 13
B. Required Behavioral Health Service Components 14
1. Family Support, Advocacy, and Care Coordination 14
2. Behavioral Health Service Components 16
C. Intervention Summary and Preliminary Theory of Change 22
V. Identifying What Works: Agency-Based Program Evaluation 23
A. General Issues in Designing an Evaluation 23
B. Potential Outcome Domains for Early Intervention Programs 24
1. Child Development 24
2. Caregiver/Family Functioning 25
3. Family Health and Safety 25
4. Service Integration 25
5. Other Associated Outcomes 25
C. Measuring Key Outcome Domains 25
D. The SESS National Cross-Site Evaluation 26
VI. Summary and Conclusions 29
VII. References 31

APPENDICES 39
Appendix A. Sample Family-Needs Map 40
Appendix B. Sample Agency-Needs Map 41
Appendix C. Sample Family-Assets Map 42
Appendix D. Sample Agency-Assets Map 43
Appendix E. Map of Potential SESS Partners 44
Appendix F. SESS Conceptual Model of Change 45
Appendix G. Mission Statements of the SESS National Collaborators 46
Appendix H. *Starting Early Starting Smart* Grant Sites 47

EXHIBITS

Exhibit 1. Considering Diversity Factors in Integrated Behavioral Health Service Delivery 5

Exhibit 2. Key Concepts Applicable to a SESS Intervention Approach 13

Exhibit 3. Behavioral Health Service Components 14

Exhibit 4. Key Outcome Domains and Indicators: A Sampling of Potential Measures 26-28

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The emphasis in SESS is on the integration of behavioral health services into easily accessible, non-threatening settings where caregivers naturally and regularly take their young children. . . Throughout these activities, SESS programs advocate a relationship-oriented approach at all systems levels, including parent-child, family-staff, staff-agency, and agency-agency interactions.

SESS

EXECUTIVE SUMMARY

This paper describes the *Starting Early Starting Smart* (SESS) project, an early intervention program that has been developed in the context of the national, multi-site program and evaluation funded by the Substance Abuse and Mental Health Services Administration and Casey Family Programs. The emphasis in SESS is on the integration of behavioral health services into easily accessible, non-threatening settings where caregivers naturally and regularly take their young children. Current SESS sites are based in primary pediatric health care and early childhood educational settings. The major goal of this early intervention service integration approach is to increase access and utilization of needed behavioral health services by families with young children, thereby improving child and family outcomes and resiliency. The focus is on providing and coordinating prevention and early intervention activities for young children as well as their adult caregivers and siblings to strengthen the entire family. Throughout these activities, SESS programs advocate a relationship-oriented approach at all systems levels, including parent-child, family-staff, staff-agency, and agency-agency interactions.

The purpose of this paper is to assist policymakers and program administrators in replicating the SESS approach by describing its essential philosophical principles and structural components. These principles and components were identified based on the evidence-based intervention components incorporated into many of the SESS sites, current worker "practice wisdom," conversations with families, and the lessons learned from the initial research data. (More definitive evaluation data will be available by November 2001. See the SESS Web site reference on the inside cover of this paper.) In addition to the description of the SESS philosophy, a general overview of the implementation and planning processes is provided, including: the importance of a comprehensive community assessment that captures information regarding the resources and needs of both the target population and service providers of the community; approaches to facilitate family involvement and

participatory planning; the development of a SESS collaborative that includes a range of stakeholders, including families, service providers, agencies, and the community-at-large; the importance of providing staff support, training, and supervision to facilitate retention of high-quality staff and program success; approaches to recruitment and retention of SESS participants in intervention services; and the need to think about sustainability from the conception of programs.

Within the context of the general SESS philosophy and implementation information, a menu of options or a "blueprint" with regard to specific intervention activities and evaluation approaches is presented. There is no single, universally imposed SESS intervention protocol, but rather this must be developed on a site-by-site basis to tailor the overall program plan to the specific population, setting, and community served, within the guidelines of the key SESS philosophical principles. SESS services should be comprehensive and responsive across time, culturally competent, strength-based, and family-centered.

Behavioral health services are defined as substance abuse prevention, substance abuse treatment, mental health services, and family/parenting services. Tying these areas together in a service integration approach is the provision of family support, advocacy, and care coordination that addresses medical, educational and basic needs, as well as coordinating behavioral health and other services for families. Care coordinators are a central contact for families, but only one part of a multidisciplinary intervention team. Strong rapport is essential. This often develops as a result of regular contacts and a facilitated referral and follow-up process with families, with at times intensive assistance from care coordinators and the multidisciplinary team. At a minimum, SESS programs should have available within each behavioral health service area ongoing screening, assessment and referral options. In addition, some direct intervention activities in each area should be offered, although programs may choose from a progression of options that vary in intensity and duration depending on the needs of the target population and setting.

Similar to the flexible approach to selecting intervention components, the development of a program's logic model and evaluation strategies must be tailored to fit the specific program goals and intervention design, as well as the agency and community needs and resources. Evaluation options are presented that cover several major outcome domains of potential interest to early intervention programs, including child development, caregiver/family functioning, family health and safety, service integration, and other associated outcomes. In addition, information regarding a sampling of potential measures within each domain is provided as a starting point for developing a local evaluation plan.

In conclusion, there are no absolute or perfect solutions to designing a SESS early intervention program, but this paper has set forth some general guiding principles, as well as valid options and choices to enable communities to begin the process of developing a tailored SESS approach that can work best in the context of a particular setting, population, and community.

Behavioral health services are defined as substance abuse prevention, substance abuse treatment, mental health services, and family/parenting services. Tying these areas together in a service integration approach is the provision of family support, advocacy, and care coordination that addresses medical, educational and basic needs, as well as coordinating behavioral health and other services for families.

I

PURPOSE AND PROGRAM OVERVIEW

Given recent advances in research on brain development and other aspects of early child development, the fields of early childhood, mental health, and child welfare are increasingly recognizing the value of early intervention with young children and their families (Center for Substance Abuse Prevention, 1998a; Grover, 1998; Knitzer, 2000). This paper describes a set of program principles derived from the experiences of the national, multi-site *Starting Early Starting Smart* (SESS) program and evaluation. The SESS program components reflect this growing awareness of the importance of targeting positive interventions to very young children. The infant and preschool years lay a critical foundation for later growth and development. Successful interventions for very young children must meet the multiple behavioral health, physical health, and educational needs of entire families. Yet, families with multiple needs often find it difficult to access services in a fragmented service system. The SESS programs reflect the importance of offering behavioral health services and integrating them into places where parents and caregivers regularly take their children. These programs not only help strengthen parents and their children, but also can prevent serious problems in the future.

A broad overview of the SESS intervention framework, developed in response to these needs, is presented here as a guide to the process of program development. Rather than attempting to develop a precise practice protocol, we are providing a "blueprint" for implementing a prevention and/or early intervention program. This blueprint is a concrete and detailed framework designed to help other community-based service providers successfully replicate core elements of the SESS intervention. In this paper we will articulate the essential SESS philosophical principles and structural components.

In 1999, *Starting Early Starting Smart* was cited by the Department of Health and Human Services as an example of a new and successful prevention intervention working with pregnant and parenting women and their young children to address behavioral health problems.

II

PHILOSOPHICAL PRINCIPLES AND UNDERPINNINGS

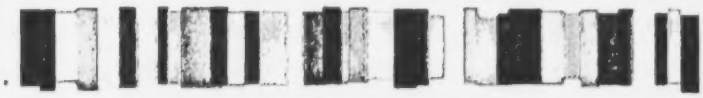
A. THE SESS PHILOSOPHY

Starting Early Starting Smart (SESS) was developed through a collaborative partnership between Casey Family Programs and the Office of Early Childhood of the Substance Abuse and Mental Health Service Administration (SAMHSA). The goals of this *first ever* public-private partnership at SAMHSA were to develop and disseminate new knowledge and information about how best to integrate and provide behavioral health services (i.e., services targeting mental health and substance abuse) to young children and their caregivers. To accomplish this task, prevention and treatment services were integrated within settings that already served young children, including five pediatric primary care settings and seven early childhood education settings. The 12 SESS sites (listed on the back inside cover), located in nine States, have participated in a 4-year cross-site research study to evaluate the efficacy of this intervention model. In 1999, *Starting Early Starting Smart* was cited by the Department of Health and Human Services as an example of a new and successful prevention intervention working with pregnant and parenting women and their young children to address behavioral health problems (U.S. Department of Health and Human Services, 1999).

Rather than adhering to an imposed intervention protocol, each site developed interventions tailored for their particular settings, communities, and families using key SESS principles to guide development and implementation. Programs, staff, and the interventions are flexible and work to accommodate the needs of the population served. However, all sites use common intervention components, including mental health and substance abuse prevention and treatment services, parenting education and support, and care coordination and family advocacy.

The guiding principle that is a theme throughout all SESS programs can be summed up with the

The SESS "Golden Rule" dictates that agencies should treat staff in the same manner they would like the staff to treat families. This parallel process of an agency nurturing its staff can significantly affect how staff nurture families. Staff who feel supported and valued can model ways in which parents can support and value their children.



phrase, *"it's all in the relationship."* Clinical, collaborative, and administrative efforts are all relationship-oriented, focusing on positive parent-child, family-staff, staff-agency, and agency-agency interactions. The success of this work depends first and foremost upon positive rapport and trust building with families through an ongoing, consistent, and supportive professional relationship, which will facilitate disclosure of behavioral health issues over time. For this reason, high quality, committed staff are essential to success. The SESS "Golden Rule" dictates that agencies should treat staff in the same manner they would like the staff to treat families. This parallel process of an agency nurturing its staff can significantly affect how staff nurture families. Staff who feel supported and valued can model ways in which parents can support and value their children.

Furthermore, SESS prevention and early intervention strategies are comprehensive and adapted for diverse racial and ethnic populations. This requires the application of a strength-based approach to individually tailor services based on a family needs assessment, and the provision of comprehensive and responsive services over time to allow for sufficient dosage levels.

In order to facilitate or build a SESS program, it is necessary to move away from traditional approaches in the delivery of services for young children and move into a more family-centered model of care. Traditional approaches have been primarily based on a model of service delivery that focuses on deficits, has restrictive participation and definitions of "family," relies heavily on technology and research while undervaluing the importance of human interaction, and is system- or provider-driven. In contrast, family-centered care emphasizes a philosophical shift from deficits to strengths, from control to collaboration, from an expert model to a partnership model, from gate-keeping to sharing, and from dependence to empowerment. This approach supports young children's development and well-being, supports family decision making and caregiving, fosters families' independence, respects children and family choices, builds on child and family strengths, and involves families in all aspects of evaluation, planning, and delivery of services (see for example, Federation of Families for Children's Mental Health, 2001).

The SESS sites collectively identified a broad conceptual approach to serve as a unifying and predictive framework. This approach was based upon the sites' recognition of the primary importance of relationships, the need to identify families-in-need early, and agreement that integrated services must involve a comprehensive and holistic system of care. Programs, staff, and the interventions must be flexible and must accommodate the needs of the population served. An *a priori* assumption is that integrated services can be built upon already existing foundations. It is assumed that some of these services already exist with varying levels of integration. Initiating a program with these assumptions in mind shifts the emphasis to developing the concept of "value-added" services, that is, what additional services, resources, and structures might be required to more effectively integrate behavioral health services in the existing setting?

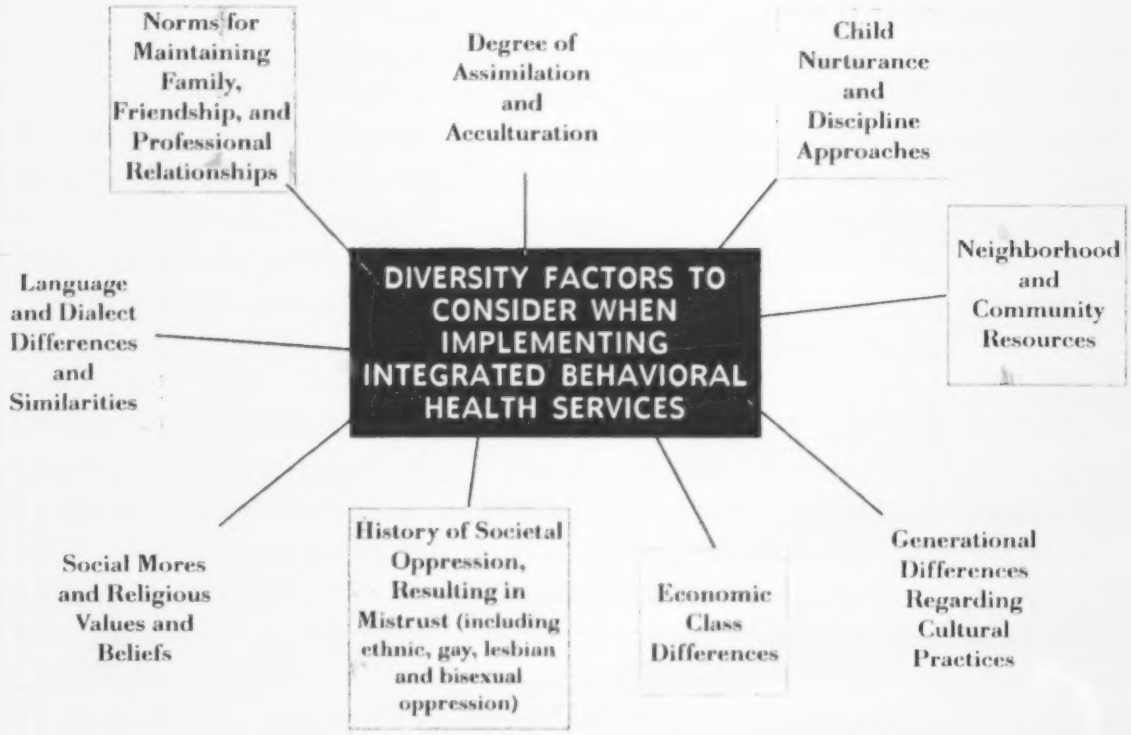
B. CULTURAL COMPETENCE

Families need access to culturally, linguistically, and age-appropriate services. (For more detail see Cross et al., 1989.) Families reflect cultural diversity in their values and beliefs, and in the views and expectations they have for themselves, their children, and their providers. Understanding diversity is particularly important when considering a family's perceptions of illness, wellness and health, child rearing practices, and developmental expectations for children. Staff must be knowledgeable about both mainstream parenting practices and beliefs from other cultural perspectives, and ideally will reflect the multilingual

and multicultural diversity of the families with whom they work. It is therefore imperative to move away from viewing "difference" as pathology and instead consider it as a reflection of cultural history and values (U.S. Department of Health and Human Services, 2000). Exhibit 1 indicates some of the many diversity factors that must be considered when implementing integrated behavioral health services, ranging from individual to family, community, and historical factors.

The Center for Substance Abuse Prevention has published guidelines for assessing cultural competence, which include consideration of organizational experience with the target population, training and staffing issues, language, materials used in interventions, program evaluation methods and instruments, community representation in participatory planning, and the implementation process (Center for Substance Abuse Prevention, 2001). At the agency level, there should be a track record of positive involvement with the target population. Staff should be representative of or familiar with the community being served, and should receive training in gender, age, and cultural competence. Resources and services should be available in a multi-linguistic format appropriate to the target population, and materials used in interventions should be gender, age, and culturally relevant. In terms of evaluation, providers need to be aware of the limitations of screening and assessment tools and carefully select the most culturally relevant tools when assessing children and families from diverse cultural backgrounds. For example, appreciation for the cultural differences in parenting styles and in fostering developmental competencies in children must be taken into account when evaluating and interpreting children's behavioral and developmental outcomes. The target population should be a planned participant in all phases of program design, as described in Section III-B below. In order to facilitate program success and avoid pitfalls, interventions must be designed to honor and respect each family's traditions, values, and beliefs.

EXHIBIT 1.
CONSIDERING DIVERSITY FACTORS IN INTEGRATED BEHAVIORAL HEALTH SERVICE DELIVERY


DIVERSITY FACTORS TO CONSIDER WHEN IMPLEMENTING INTEGRATED BEHAVIORAL HEALTH SERVICES
Norms for Maintaining Family, Friendship, and Professional Relationships
Degree of Assimilation and Acculturation
Child Nurturance and Discipline Approaches
Language and Dialect Differences and Similarities
Neighborhood and Community Resources
Social Mores and Religious Values and Beliefs
History of Societal Oppression, Resulting in Mistrust (including ethnic, gay, lesbian and bisexual oppression)
Economic Class Differences
Generational Differences Regarding Cultural Practices

As indicated in Exhibit 1, other personal identity factors must also be considered, including social identity and physical disabilities. These areas of practice diversity are often not mentioned but form a core part of a practice approach that respects diversity and builds on individual, family, and community strengths.

C. SERVICE INTEGRATION

For the current SESS programs, service integration involves a system of care that includes behavioral health services as a part of a more holistic approach to comprehensive care for young children and their families offered in either pediatric primary care or early childhood education settings. Behavioral health services include the prevention, assessment and treatment of substance abuse and mental health difficulties. In the case of SESS, the focus is on the entire family, including children and their caregivers. Service integration of behavioral health care within child-serving settings can take a variety of forms in varying contexts. In primary care settings, for example, parents of newborns could be targeted for substance abuse treatment and parenting classes, while the newborn receives neonatal assessment and other family members receive family counseling. This can all occur through joint, shared case assessment and planning, resulting in shared outcome goals for the family. In the case of early childhood settings, parents involved with child protective services who are receiving foster care preventive or reunification services could receive child care services, mental health counseling, substance abuse treatment and/or parent training, using common assessment, planning and care coordination (Pecora, Bernstein, & Springer, 1999).

The SESS integrated services approach offers behavioral health services that are both family-centered and child-friendly. It requires a multidisciplinary team effort, including family members as part of the team, to provide services in response to family needs within a provider setting that does not customarily offer such services. This collaborative team approach requires full utilization of existing services, and the coordination of such services to (a) eliminate fragmentation and duplication in service delivery; and (b) ensure all service providers have knowledge of pertinent information from all sources.

Furthermore, cross-program relationships should be strengthened through mechanisms such as joint staffing, consultation among service providers, cross-training, and family involvement. Partnerships or collaborative arrangements beyond simple referral arrangements are a key component of integrated services. Further discussion of collaboration is included in Section III-C. The goal of integrating services in a SESS approach is to improve services and their availability and delivery, within a coordinated, efficient system. However, it should be noted that system and service integration are not "magic bullets." In fact, other program fundamentals are just as or more important, such as program fidelity, positive organizational climates, staff personal efficacy, relationship-building skills, and cultural competence (Dennis, Steadman, & Cocozza, 2000; Glisson & Hemmelgarn, 1998; Kumpfer, 1999).

D. POTENTIAL SESS SETTINGS

The SESS approach can be adapted for many settings that serve families with young children. This approach is appropriate for families who struggle with accessing and utilizing community-based services, including those that address financial, social, educational, physical health, and behavioral health needs. The key concept is integrating behavioral health services into easily accessible, non-threatening places where families naturally go. In addition to early childhood education centers such as Head Start, and primary pediatric health care clinics, this approach could potentially be implemented in a variety of other such settings. For example, some places families naturally attend that do not typically include fully integrated behavioral health services include public health programs, family practice health care clinics, child daycare programs, child welfare agencies, substance abuse or mental health treatment centers lacking comprehensive behavioral health services, social services agencies, public housing or community centers, and faith-based institutions. Collaborations should be developed between service providers and the most appropriate host setting, as described in Section III-C.

III. IMPLEMENTING A SESS PROGRAM

There are several existing resources for step-by-step guides to program implementation, including the Center for Substance Abuse Prevention Web-based Decision Support System (Center for Substance Abuse Prevention, 2000) and the Western Center for the Application of Preventive Technologies (Western Regional Center for the Application of Prevention Technologies, 2000). This section is intended to offer an introductory overview of the initial implementation steps of community assessment, family involvement, collaboration, staff support, recruitment and retention of participants, and sustainability.

A. COMMUNITY ASSESSMENT

A necessary first step in planning any community project is a comprehensive assessment of the community in which the project will take place. Many projects fail to realize their potential because they do not adequately understand their community and its resources. Even long-time residents of a community often overlook some of the existing barriers or resources. Community assessments are multifaceted. A complete assessment must provide a clear demographic picture of the targeted community and include resource assessment as well as needs assessment. A thorough assessment of the community will address issues for the target population as well as for service providers. For example, upon what key outcomes does a particular community place emphasis? For what outcome indicators are children and families doing most poorly? Where are they the most successful? What key gaps in service need to be addressed? Identification of strengths is as essential as identification of existing deficits. Potential SESS providers may wish to develop specialized community assessments, but much can be learned from reviewing routine community assessments that are already being completed by providers such as health departments, Head Start, community mental health agencies, disability coalitions, community action agencies, public schools, and local governments.

The community assessment will be most revealing if completed in collaboration with existing

If interventions are to benefit families, they deserve the right to be part of service delivery design and monitoring, as well as evaluation efforts after completion of a program. If the project is to achieve maximum success, families must have been viewed as full partners.

organizations and as a result of an evolutionary process. Existing task forces, multidisciplinary teams, and human service coalitions may be the most efficient sources of identifying existing community needs assessments and potential SESS partners. This process of identification is a foundation in the early development of a SESS collaborative.

A mistake often made in conducting community assessments is limiting the assessment to a focus that is too narrow. By beginning with a wide view of the community, and including all possible assets and deficits, planners often discover that some of the most important findings are in areas not initially seen as the target. The most helpful collaborators may come from sources not initially identified as part of the potential pool. One can always focus the utilization of findings after completion of the assessment, but expanding the focus afterward is more difficult.

Asset mapping can provide an excellent format for ensuring that communities do not focus exclusively on problems or deficits. Kretzmann and McKnight (1993) describe an approach to conducting assessments using such maps. Based on this work, Appendices A-E provide examples of maps of family and agency assets and needs, as well as potential program partners.

B. FAMILY INVOLVEMENT

As mentioned previously, a guiding principle among SESS programs is the philosophy that, "*it's all in the relationship.*" Relationships with families are developed not only through service delivery, but also through direct involvement in program administration (see for example, Federation of Families for Children's Mental Health, 2001). By securing family involvement in planning, implementation, and evaluation, relationships are continuously fostered. This is not only an ethical imperative, but a pragmatic one as well.

Ethically, as consumers, families have the right to contribute to how they are offered services. If interventions are to benefit families, they deserve the right to be a part of service delivery design and monitoring, as well as evaluation efforts after completion of a program. If the project is to achieve maximum success, families must be viewed as full partners.

Pragmatically, when families are collaborators in all stages of intervention programs, their level of investment and engagement will increase. Too often, planners for health and social service programs operate in isolation from the people the programs are to benefit. Such isolation can result in limited success due to reduced involvement of participants in interventions, inadequate information concerning what participants want and need, and lack of understanding about barriers to the involvement of families. For example, a decision as simple as where to hold meetings could profoundly affect the program if participants are not included in the process and planners are unaware of negative associations with a facility.

Families should be involved in all stages of program development, including planning, implementation, and evaluation. There are several opportunities for family involvement during the ***planning*** phase of a project. The strongest strategy for family involvement is to include family members on the planning team. By including families at that level, every aspect of the project can be consistent with family perspectives. However, projects should not allow the voices of one or two family participants to be the only ones heard. The project should take care to secure a broad perspective from multiple families. Focus groups and surveys can provide needed consumer input concerning strengths, needs, and preferences.

When the project reaches the ***implementation*** stage, it might use family members as a part of the

local steering committee or advisory board. These family members will be able to provide ongoing insight into the reasons interventions are working well or ways to improve them. As a part of ongoing monitoring and continuous improvement, families can provide rich information through satisfaction or needs surveys, focus groups with families to evaluate program quality and effectiveness, and focus groups with staff members to capture informal feedback they have received from families. Some SESS projects have found some of their strongest staff members through hiring former program participants.

When projects design and conduct ***evaluations***, families may collaborate in determining what to assess and how best to conduct the assessment. The project should include families in process and outcome evaluation efforts. As in the planning phase, surveys may provide insight into perceptions of the level of respect given the families, helpfulness of staff members, family-centeredness, accessibility of services, cultural relevance, and barriers to services.

C. COLLABORATION

In order for SESS to work, collaboration among a range of stakeholders is imperative. The lead agency must work with families, components of their own agency, other agencies, and the community-at-large. Some examples of collaborative partners include family members, mental health providers, substance abuse treatment providers, youth services, educational settings, child welfare agencies, social service agencies, health care providers, criminal justice agencies, faith-based service programs, and public health initiatives. The choice of collaborators and services should be based on local resources and the needs of the target population.

Collaboration takes time and will require commitments at a minimum of three traditional levels: administration, mid-level management, and those at the field level of service. It is a fluid, rather than a static process. The most essential ingredient for a successful collaboration is the right attitude. Collaborators should expect the process to be challenging and frustrating. Commitment to open communication, the families to be served, and most importantly, to conflict resolution is paramount. If staff members of the project see collaboration as essential to the success of the project, they will find a way to achieve it.

In order for the collaboration to succeed, there must be benefits for each party. To stay engaged in the process over a period of time, each stakeholder must be able to clearly define his or her needs and the group must work to see that each entity achieves some of its goals through the collaboration. The exploration of the goals and objectives of a SESS project are also good building blocks for a new collaboration. These goals and objectives should be clearly defined in order to avoid confusion. Service determination is also easy to define with a clear resource assessment and clarified goals. Formal communication through regularly scheduled meetings is important, but no more important than communication through more relaxed interactions. The most effective communication may combine formal and informal structures. Serving refreshments and scheduling

Family-driven services can only be built on respect at all levels, including among provider communities.

working lunches or dinner meetings can be a beneficial way of providing formal communication in a comfortable atmosphere.

Interagency training around common interest and needs areas can be particularly valuable. Training can provide an opportunity for dialog to explore common ground, including values. Interactive training with breaks and meals also facilitates the development of new relationships and refreshes existing ones. Telephone and e-mail communications allow for the development of easy, ongoing communication. The use of e-mail list serves, if available, can also be a valuable tool to facilitate timely communication.

In contrast to "blending" services, in which agencies pool funding, resources, responsibilities, and credit, "braiding" services allows each agency to maintain responsibility and control of its activities and its resources. As with braiding fibers of a rug, services are interwoven, while remaining distinct. Braiding allows each program to maintain its own independent identification, yet it strengthens services and outcomes for all participants. The concept of braiding services and financing may be the most neutral way of avoiding turf battles and introducing service integration. A form of braided services can be co-located services, in which staff from one agency are placed at the service delivery site of another—for example, placing a mental health therapist onsite at a Head Start or pediatric primary health care center. Braided programs must work together not only at the point of service delivery, but also in the business office to adapt their structures and processes to fit together to the extent possible.

If co-located services are to be developed, communication and accountability between all of the entities is crucial. For example, shared supervision of staff (i.e., "matrix" supervision) may be necessary in that workers from one agency may be physically located in another agency, and may receive some or most of their day-to-day assignments or supervision from that organization's administrative staff.

It must also be recognized that there is stress in working in unfamiliar settings. All organizations develop their own cultures and distinct missions. Understanding and acceptance of this reality is most critical in the early phases when people can be most concerned about perceived deficiencies in each project and whether the collaboration will be worthwhile. Family-driven services can only be built on respect at all levels, including among provider communities.

An important step in establishing a collaborative relationship is the development of a formal agreement. The type of written agreement will depend on the level of commitment. The choice to use a letter of support, letter of commitment, consultant agreement, letter of cooperation, collaboration agreement, memorandum of

understanding or agreement, or a contractual agreement will be dictated by the amount of investment in the project. (For example, see COSMOS, 2001.)

Collaboration is always difficult. It is time consuming and expensive, especially in the early years. "*We will do it ourselves*," is an easy trap to fall into, yet it results in further fragmentation of services and ultimately duplication of costs. Investing time is an imperative part of establishing new projects and working with agencies and parents. Trust among providers and between providers and families takes time to develop. Ultimately, this investment of time and resources is necessary to enhance benefits and program success. There are many rich resources available on developing collaborative relationships. Developers of SESS projects should particularly consult "Lessons Learned: Implementation of Community Interventions" (Phillips & Springer, 2000).

D. STAFF SUPPORT, TRAINING, AND SUPERVISION

As described earlier, the application of a relationship-oriented approach necessarily involves attention to how well staff are supported and nurtured by the SESS program. Those who have worked with families at risk well appreciate the disruption caused by staff turnover. Because of the critical role direct service staff play in building trust and rapport with families, recruitment and retention of committed, qualified staff are essential to both family and program success (Kumpfer, 1999). Modeling a strength-based, solution-focused approach with staff will make it easier and more natural for them to practice these approaches with their clients. Ideally, when recruiting direct service staff, SESS program administrators seek people from various disciplines and cultural backgrounds, who function well in a multidisciplinary team-oriented service approach. Dedication and commitment to serving the target population or community, as well as overall "buy-in" to the general SESS philosophy and approach are important to program fidelity. Finally, staff members should be culturally and professionally competent.

SESS programs make a commitment to staff by providing appropriate support through regular training and supervision. Broad areas of service-staff training initially viewed as important in current SESS sites included general service delivery approaches, specific work skills, personal development and competencies (e.g., coping with stress, time management), specific curriculum strategies being used, working with the community, case management assessment and referral, cross-disciplinary perspectives, and collaboration procedures. Regular and ongoing supervision by licensed or clinically skilled professionals is not only critical to appropriate service delivery for families, but also to addressing pertinent issues with direct service staff members (e.g., skill development, reduction of stress and frustration that may lead to burnout). In addition, programmatic support of staff is provided through setting caseload limits appropriate to the intensity level of service provision expected, providing adequate work space and supplies, and compensating staff at reasonable and appropriate rates.

E. RECRUITMENT AND RETENTION OF SESS PARTICIPANTS

Although many documentation and data collection systems typically require a "target" or "index" client, SESS programs serve the family in a holistic

Regular and ongoing supervision by licensed or clinically skilled professionals is not only critical to appropriate service delivery for families, but also to addressing pertinent issues with direct service staff members (e.g., skill development, reduction of stress and frustration that may lead to burnout).

manner, addressing the needs of the child, caregivers, siblings, and other extended family members when appropriate. Selection of families for enrollment might be based on the presence of potential risk factors, such as families receiving pubic assistance (e.g., TANF), substantially below income guidelines, or with single parents; parents with less than an 8th grade education, a disability, or a substance abuse problem; or children under protective services or with a disability. Priority status may be assigned to those with the most risk factors, or to those with the highest scores after summing weighted scores for the various risk factors. Each program will need to determine the risk factors for their target population based on their goals and the risks specific to their locale.

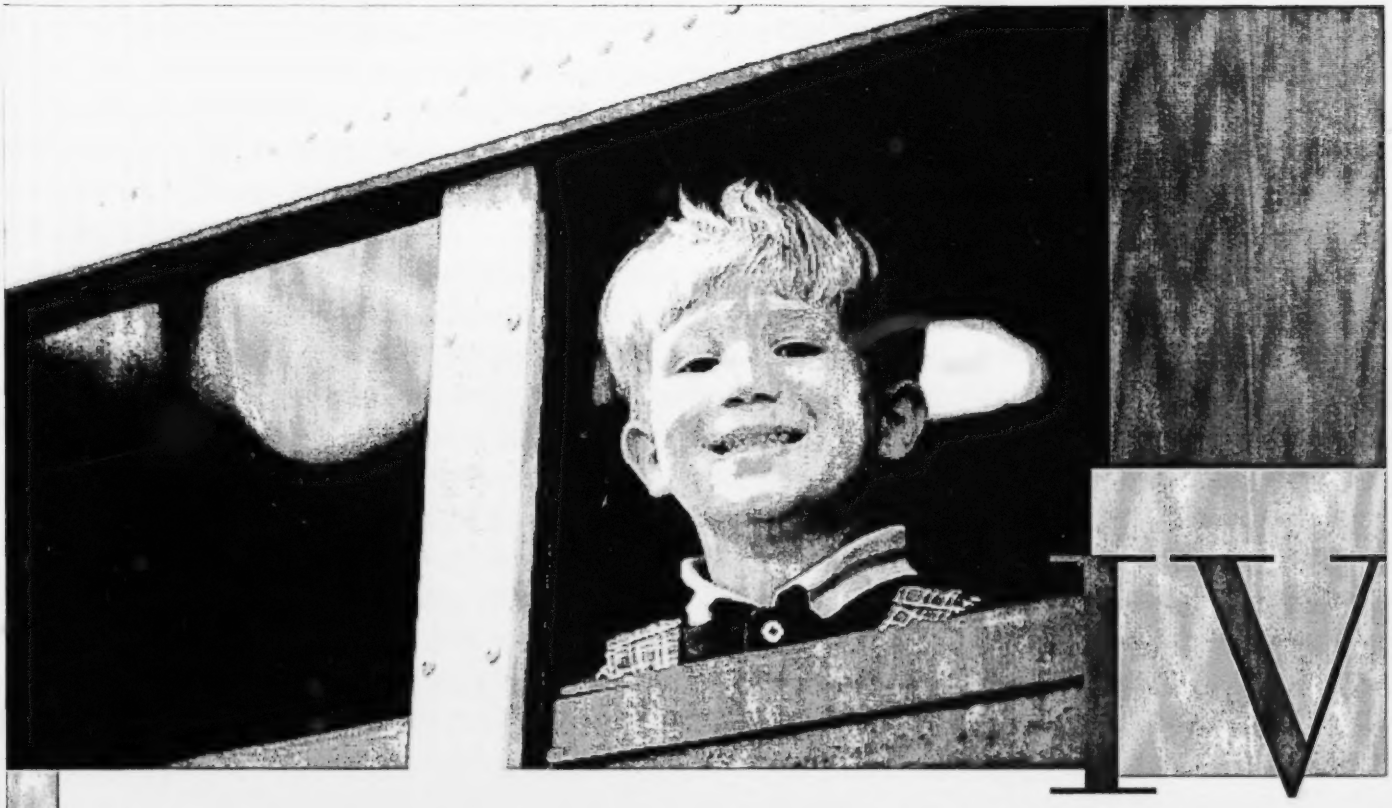
The method of identifying families for SESS intensive services will vary among projects. Each individual program will shape their identification process based on their program's eligibility requirements. Nontraditional settings require broader and more flexible ongoing assessments. Assessments may involve formal instruments and clinical history as a way to identify the presence and severity of behavioral health problems. Sites with ongoing family contacts may also rely on informal procedures that are based in ongoing observations and insight resulting from developed relationships. As is the case when assessing communities and agencies, including strengths in any assessment of individuals or families is paramount. As staff members are engaged in identification activities, they are also beginning to build trust with families. Trust is facilitated by asking questions in a relaxed and friendly manner, and by helping families with their most pressing priorities.

The SESS relationship-focused philosophy permeates the approach to retention of participants as well as recruitment and initial assessment. Trust and respect are paramount and must be given time to develop. In order for staff and other providers to be seen as approachable, opportunities for informal interaction must be provided. All services must be designed as family-friendly, culturally relevant, and strength-based. One basic key to engaging families into services is to maintain a flexible schedule of when and how services are provided. Opportunities for program involvement should be made available at various days, times, and convenient locations (including center and home-based activities). In addition, programs must address concrete barriers to participation, including needs for transportation and child care. Other methods of engaging families in interventions include serving food, providing token gifts or "door prizes," making reminder calls, following-up promptly when appointments are missed, emphasizing the value and worth of the services offered, including extended family or significant others in activities, and celebrating family progress and accomplishments.

F. SUSTAINABILITY

Sustainability should be a part of the work of the project from the first day. As one builds collaborative relationships, the project begins to sustain itself. When thinking about a sustainability plan, one should avoid the trap of thinking only of funding sources. Many collaborators are positioned to supply various types of support for a project. Co-locating services at another agency can be a way to help both agencies fulfill their missions. Developing close working relationships among the employees of multiple agencies can be a way of more effectively integrating services. Often agencies are already working with the same families. Increased communication can be a way to accomplish integration of services for those families.

The inescapable reality for most programs, however, is that additional funding is necessary for a SESS project. Collaborators may themselves become funders or have connections with potential funders. (See COSMOS, 2001.) A thorough community assessment will likely identify the best options for collaborators in both service provision and funding. Some sources of ongoing funding for existing SESS projects have come from State and local government (by tapping into existing funding streams and through grants or line items in budgets), local universities, local foundations, and subcontracts with other agencies. For more detailed information regarding approaches to sustaining programs focused on children's mental health, please refer to Koyanagi and Feres-Merchant (2000).



IV

BUILDING AN INTERVENTION APPROACH

A. BASIC FOUNDATIONS OF INTEGRATED BEHAVIORAL HEALTH SERVICES

Exhibit 2 lists some of the key concepts or components applicable to the basic foundation of building a SESS intervention model. Most of these concepts have been described previously, but should be kept in mind when designing program intervention components.

As stated, implementing a SESS service integration program requires the ability to tailor services to meet the needs of individual families, agencies, and communities. There is no single universally implemented SESS intervention protocol. Specific SESS components are developed and implemented to meet the developmental, prevention, and/or treatment needs of families served. "Bundles" of various intervention strategies may be arranged in a variety of packages based on a community needs

EXHIBIT 2.
KEY CONCEPTS APPLICABLE TO A SESS INTERVENTION APPROACH

- Behavioral Health Sciences
- Family-Centered
- Individually Tailored Services
- Culturally Competent
- Relationship-Oriented
- Strength-Based
- Holistic
- Service Integration
- Multidisciplinary Team
- Collaboration
- Co-Location of Services
- Comprehensive
- Enduring/Sufficient Dosage
- Prevention/Early Intervention

assessment, but with a common underlying philosophy that includes the key concepts above and informs and guides the development and provision of interventions.

Overall, the emphasis of SESS interventions is on providing services early in a preventive manner before problems become more serious, resulting in higher human costs for children and families and higher financial costs of more extensive service provision. Prevention and intervention programs can be classified as *universal*, *selective*, and *indicated* (Mrazek & Haggerty, 1994). *Universal* programs target a general population without identifying those at particularly high risk. All members of the community benefit from prevention efforts rather than specific individuals or groups within a community. *Selective* programs target those who are at greater-than-average risk for behavioral health difficulties. The targeted individuals are identified based on the nature and number of risk factors to which they may be exposed. *Indicated* programs are aimed at individuals who may already display signs of behavioral health problems. These efforts provide intensive programming for individuals to prevent the onset of major difficulties or to ameliorate those that already exist. SESS service approaches may include *universal*, *selective*, and/or *indicated* prevention services. The distinctions between these prevention and intervention strategies, however, often become blurred when working with families in the real world.

Various strength-based and solution-focused models lend themselves well to the SESS philosophy and foundation (e.g., Berg, 1994; de Shazer, 1985; de Shazer et al., 1986; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992; Zimmerman, Jacobsen, MacIntyre, & Watson, 1996). Utilizing and highlighting a family's adaptive resources and allowing their level of motivation for change to guide the intervention process is respectful and facilitates success. In addition, the SESS approach recognizes the importance of addressing risk factors while increasing protective factors, since research shows the more risk factors a child experiences the more likely they are to experience behavioral health problems later in life (Hawkins, Catalano, & Miller, 1992). Prevention and intervention approaches must be combined to both increase protective factors and reduce risk factors within a child's family and home environment, since families contribute both protection and risk to a child's life (Belcher & Shinitzky, 1998; U.S. Department of Health and Human Services, 2000).

B. REQUIRED BEHAVIORAL HEALTH SERVICE COMPONENTS

Exhibit 3 diagrams the required behavioral health service components in a SESS program. Each behavioral health service component is shown as a spoke on a wheel, with the core family support services in the center hub, linking interventions together with the family.

1. Family Support, Advocacy, and Care Coordination: The core component, or "hub" of the intervention wheel, is the provision of comprehensive, wrap-around services referred to variously as Family Advocacy, Care Coordination, or Case Management (all used interchangeably here). These services are delivered within the context of a familiar and accessible setting by a central provider who is then supported by a more

EXHIBIT 3. BEHAVIORAL HEALTH SERVICE COMPONENTS

extensive multidisciplinary team and on-call crisis intervention staff. Utilization levels of the on-call crisis intervention staff will vary depending on the severity of risk in the population served; however, it is ideal for these services to be flexibly available both onsite and in the home. The multidisciplinary team should include families in treatment and program decisions. The team should meet regularly (weekly works well) to jointly staff cases. Multidisciplinary team members may include family members, child development specialists, physicians, nurses, educators, social workers, psychologists, health care providers, mental health providers, substance abuse specialists, and others. Working together on a regular basis allows team members to get to know each other's strengths, skills, and clinical expertise. Further, the team becomes familiar with all program families and is therefore better able to provide for a broad range of needs.

Intensive, integrated care coordination is in sharp contrast to traditional case management where the staff have large case loads and work only in the office setting to make calls and offer linkage referrals. Traditional approaches frequently offer little or no follow-up or in-depth involvement with clients. The emphasis in the SESS approach is on the process of building trust and rapport with families through an ongoing, supportive relationship. In order for this to succeed, there must be a central person who is in frequent contact with the family through telephone calls, home visits, and meetings onsite and elsewhere in the community.

Through the development of relationships with families, the Family Advocate identifies service needs, helps families utilize services, and empowers families. Identification of service needs may include formal and informal assessments or interviews with families, as well as general observations onsite and in home environments. Helping families utilize services involves the provision of logistical support, such as scheduling and following-up on service appointments, assisting with paperwork, providing transportation to service locations, translating, and arranging child care during appointments.

The referral process in the SESS approach utilizes facilitated referrals, rather than traditional linkage referrals that simply provide clients with phone numbers and encourage them to make contact on their own. In a facilitated referral approach, Family Advocates communicate with the referral agency directly and may offer a specific contact person for families, perhaps even accompanying the client to the appointment. The process also incorporates routine follow-up to ensure needed services are received, and any barriers to service access are reduced or overcome.

Empowering families is a process that varies based on where each family is on an independence-readiness continuum. Family Advocates allow and encourage families to take responsibility for meeting their own needs by having parents identify and prioritize their most pressing problems, educating families about accessing service systems, and inviting family participation in the multidisciplinary team and program planning.

Initial and ongoing family needs are assessed by Family Advocates in multiple areas, not only behavioral health. Basic and social service needs often must be addressed for the benefits of behavioral health services to be realized. Human needs are best understood in a hierarchy (Maslow, 1970), which holds that if basic needs are unmet, it is difficult to focus on other, more advanced needs. Some basic needs current SESS programs have found often require attention include housing, food, clothing, financial assistance, vocational or employment services, child care, legal services, and the like. Another key area to be assessed and addressed is physical health care of both the children and adults in a family. This may include consultation with medical providers, high-risk nursing follow-up services, health education/ prevention, assistance obtaining medical insurance coverage, and facilitating needed medical appointments for children (e.g., well- and sick-child visits, timely immunizations) and adults (e.g., routine medical care, family planning services).

This needs assessment, combined with multidisciplinary staff input regarding specific behavioral health issues, contributes to an individualized service plan developed through a strength-based, family-participatory process. While there are many intervention program components that may be offered, the most efficacious occur when services are matched to the individual family needs through this planning process. In essence, there is no particular best intervention approach, but it is the delivery of carefully chosen programs, within the service integration's basic foundation and the context of a trusting relationship, that is most important.

2. Behavioral Health Service Components: As described, core Behavioral Health Service Components include Substance Abuse Prevention, Substance Abuse Treatment, Mental Health Services, and Family/Parenting Services. Each is represented as a "spoke" in the intervention wheel. Any SESS program should include basic screening and assessment, resource identification, and referral within each of these areas. Furthermore, assessment processes should be ongoing rather than static, one-time evaluations, since family circumstances change and disclosure may increase over time. One cannot assume after asking about behavioral health service needs once that answers remain the same.

Evaluations in the home are especially useful because they provide a picture of the family environment and parent-child interaction in a more naturalistic setting.

Substance Abuse Prevention assessment may include evaluation of both caregivers' and child(ren)'s knowledge and exposure, family history, and personal experiences with alcohol, tobacco, and other drugs (ATOD). The Substance Abuse Treatment area is more applicable to caregivers, since the typical age of onset for drug use is beyond the SESS targeted early childhood age range of 0-7 years. Evaluation in this area involves a detailed assessment of caregivers' personal history and patterns of ATOD use and treatment, beliefs or perceptions of this behavior, and ways the activity has affected daily functioning and adaptation.

Mental Health Services may be applicable to both the adult caregivers and child(ren) in a family. Adult evaluation may include brief assessment of mental status, mental, emotional, or somatic symptoms, formal diagnosis, history of or current suicidal thoughts and actions, and current level of daily functioning. For young children, early routine developmental screening of mental, motor, social, and emotional growth is an important service that can lead to early intervention and amelioration of difficulties in many cases.

Family/Parenting Services screening should include the evaluation of parenting beliefs, stressors, behaviors, and needs via formal testing and/or staff observations on site and in home environments. Evaluations in the home are especially useful because they provide a picture of the family environment and parent-child interaction in a more naturalistic setting. In addition, it is useful to learn the family's history and current status with regard

to family violence and involvement with Child Protective Services, as well as the perceived impact of substance abuse and mental health issues on parenting.

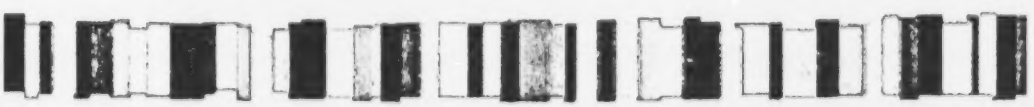
When designing a SESS integrated service program, some intervention services beyond screening and assessment should be incorporated from within each of the Behavioral Health Service categories. Programs are developed and implemented to meet the developmental, prevention and/or treatment needs of the families who are served. A particular agency's choice of which service "bundles" to select will depend on what is appropriate to the specific setting and target population. However, all resulting programs will have the common basic foundation, as described above, that informs and guides the development and provision of intervention services. Each Behavioral Health Service category listed below has within it a progression of intervention choices that vary in duration and intensity level, according to the needs and characteristics of the target population. Specific intervention recommendations are not made since there is no one single best family intervention program (Kumpfer, 1999).

There are numerous published and commercially available intervention components available, and providers should carefully select the best ones appropriate for their community's needs and resources. There are many good resources for conducting this selection process. Sloboda and David (1997) offer some guiding principles that are elaborated by Kumpfer (1999) and overlap with the SESS basic foundation principles discussed above. In addition, descriptive collections of "model" programs and "proven practices " can be found in the Strengthening America's Families Web site, CSAP's model prevention programs Web site, and the NIDA Web site (Center for Substance Abuse Prevention, 2000; National Institute on Drug Abuse, 2000; Office of Juvenile Justice and Delinquency Prevention, 2000). Decisions about what components to select should be based on sound empirical evidence and/or theoretical grounding, as well as the unique needs of the population and setting. The next sections will summarize how key aspects of substance abuse prevention, substance abuse treatment, mental health services, and family/parenting services can be provided in a SESS program.

a) Substance Abuse Prevention. A recent focus on the family environment as an important determinant of initial substance use has led to early prevention efforts that target caregivers and their children (Brounstein & Zweig, 1999; Center for Substance Abuse Prevention, 1998a; Center for Substance Abuse Prevention, 1998b; Grover, 1998). Current research advocates comprehensive community-based programs that influence individual behavior and attitudes through education and awareness of substance abuse and its consequences, engagement into formal treatment as needed, and support to reduce stress and improve overall functioning (Catalano, Haggerty, Gainey, & Hoppe, 1997; Szapocznik et al., 1988), with more intensive and earlier prevention efforts as the risk level of the target population increases (Sloboda & David, 1997; U.S. Department of Health and Human Services, 2000).

Family-focused prevention efforts will have the greatest impact if they focus on both caregivers and children, work with young children before patterns become entrenched, apply developmentally, culturally, and gender appropriate strategies, remove potential barriers to participation (e.g., transportation, child care), address multiple risks simultaneously, and build on families' strengths (Grover, 1998; Kumpfer, 1997; Szapocznik, 1997). Protective factors should also be a focus, such as increasing social support and parental self-concept and satisfaction in order to improve overall functioning and decrease likelihood of maladaptive coping styles, such as substance use. Substance abuse prevention activities in a SESS program may include:

- ☐ Distribution of multimedia educational materials in print, video, and/or audio format.
- ☐ Educational activities and curriculums that target children, adults, and/or families to



increase awareness of substance abuse and its consequences and encourage adaptive coping mechanisms for dealing with stress.

- Ongoing assessment of needs and provision of social support by SESS intervention staff.
- Encouragement of the development and maintenance of positive and appropriate family and peer support systems.

b.) Substance Abuse Treatment. The understanding of the impact of addiction upon women, children, and families has increased in recent years as a growing number of women have entered substance abuse treatment, leading to an emphasis on their unique treatment needs (Center for Substance Abuse Treatment, 1994; Leshner, 1998a). Leshner (1998a) states that most programs have been shaped by men's characteristics and needs, and thus the effects of drug abuse are far less understood for women. More recent reviews of substance abuse research emphasize the influence of gender on etiology, consequences, prevention, and treatment services. When studying female caregivers with young children, psychosocial factors such as social support, relationships with partners, and depressive symptoms may be specifically more important to understanding etiology (Leshner, 1998b). Many substance-using mothers of young children have an increased motivation to improve their functioning in order to maintain custody of their babies and preschool children (Rosenbaum & Murphy, 1996). The pregnancy and postpartum periods present prime windows of opportunity for intervention and increased motivation for change (Kumpfer, 1999). There is also evidence to suggest that women relapse less frequently than men, at least partly because women are more likely to participate in group counseling and support groups (Stocker, 1998). Intervention programs for women should be conducted in the context of a nurturing, empowering, relationship-oriented environment, and should address the needs of children, include the family in treatment, and address mental health needs (Bass & Jackson, 1997; Carten, 1996; Closser & Blow, 1993; Farkas & Parran, Jr., 1993; Finkelstein, 1996; Howell, Heiser, & Harrington, 1999; Ramlow, White, Watson, & Leukefeld, 1997; Reed, 1985; Saulnier, 1996; Schliebner, 1994).

For detailed information regarding scientifically based approaches to substance abuse treatment, readers should refer to more specialized resources (e.g., Budney & Higgins, 1998; Carroll, 1998; Carroll, 2000; Mercer & Woody, 1999; National Institute on Drug Abuse, 1999). Many of the successful approaches fit well with the strength-based, client-centered, relationship-oriented SESS approach to meeting clients at their own level of readiness for change, and in settings that are easily accessible (see for example, Henggler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Miller, 1996; Miller, 2000). Although substance abuse treatment has been shown effective, it is also true that no single treatment method is appropriate for all clients. Experts in the field recommend that treatments should be well-delivered and tailored to the needs of the particular patient (Leshner, 1999). Years of

research have demonstrated that treatment approaches consisting of behavioral and pharmacological treatments can successfully reduce drug use by 40-60 percent, as well as reduce other associated high-risk behaviors (Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997).

Generally, a SESS program does not conduct substance abuse treatment directly, so specialized treatment agencies are essential collaborative partners. It is helpful to choose a treatment agency with similar philosophical underpinnings. For example, residential treatment programs that allow parents to enter treatment with their children or outpatient programs that offer child care services are incorporating a family-centered approach to treatment. Examples of SESS substance abuse treatment intervention activities include the following:

- Training early childhood and primary health care staff regarding substance abuse treatment approaches and outcomes is important. Since general beliefs towards substance abuse tend to be negative, and treatments are often viewed as non-effective, staff in agencies that frequently come into contact with drug users may avoid addressing the issue or encouraging treatment (Leshner, 1999). Appropriate education regarding awareness of substance abuse and available effective treatment approaches can lead to a shift in attitudes and improved screening and referral behaviors among these professionals.
- An application of a stage of change or readiness for change framework, which assesses client motivation for change and targets interventions to the individual's current status while trying to move them forward on the continuum, is a helpful approach (Prochaska & DiClemente, 1986; Prochaska & DiClemente, 1992; Prochaska, DiClemente, & Norcross, 1992).
- Comprehensive, ongoing assessment of substance abuse, and potential underlying mental health diagnoses often associated with drug use should be prioritized (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998). Many adult drug users abuse substances as a way of dealing with negative life circumstances or to counteract feelings of depression or other mental disorders (Khantzian, 1985; Markou, Kosten, & Koob, 1998).
- Crisis intervention and stabilization services should be available on an on-call basis by trained professional staff.
- Often, intensive treatment engagement activities are required to achieve clients' initial entry into needed treatment programs, and to encourage retention in and completion of treatment. Successful approaches provide this support and encouragement while using the family and other significant client support systems (e.g., Dakof et al.; Quille & Dakof, 1999; Szapocznik et al., 1988).
- Referral of clients to comprehensive and quality addiction treatment programs is important in helping them learn to cope with drug cravings, ways to avoid drugs and prevent relapse, and dealing with relapse if it occurs (Leshner, 1999). Core elements of addiction treatment should include: intake assessment, treatment planning, pharmacotherapy, behavioral therapy, substance use monitoring, self-help and peer support groups, clinical and case management, and continuing care (Etheridge & Hubbard, in press; Leshner, 1999).
- SESS staff should become part of the substance abuse treatment team, maintaining ongoing consultation with treatment center staff to monitor and support client progress and assist in coordinating services.
- SESS programs may offer various group activities related to substance abuse treatment.

Many adult drug users abuse substances as a way of dealing with negative life circumstances or to counteract feelings of depression or other mental disorders.

Effective parenting, including clear communication, appropriate limit setting, and a responsive and nurturing parent-child relationship can help foster the healthy development of children and protect them from behavioral and emotional difficulties.

These include educational/didactic sessions regarding substance abuse, relapse prevention discussion and support, or providing assistance to families so they can join and/or form self-help groups to build positive and appropriate peer supports and maintain abstinence.

c.) Mental Health Services. As stated above, child and adult mental health difficulties are often interwoven with parental substance abuse risk and misuse. In addition, parental mental disorders may have significant detrimental effects on families and children regardless of involvement with substance abuse. Maternal functioning is an important factor that shapes child adjustment (Downey & Coyne, 1990; Hammen, 1992; Hammen et al., 1987; Jaffe, Wolfe, Wilson, & Zak, 1985; Lee & Gotlib, 1989a; Lee & Gotlib, 1989b; Lee & Gotlib, 1991; Mertin, 1992; Wolfe, Jaffe, Wilson, & Zak, 1985; Wolfe, Jaffe, Wilson, & Zak, 1988). For example, maternal depression can be associated with several undesirable parenting practices such as unresponsiveness, inattentiveness, intrusiveness, inept discipline, and negative perceptions of children (Gelfand & Teti, 1990), and the parent-child relationship is likely to be negatively affected in cases of chronic depression (Hughes, in press; Stoneman, Brody, & Burke, 1989). SESS mental health services targeting children may include:

- Training early childhood and primary health care staff about infant and child mental health is important, and involves addressing attitudes and beliefs as well as providing factual information.
- Universally available child intervention groups may be offered in settings where groups of children are regularly accessible. Group curriculum activities may focus on development of age-appropriate social skills, conflict resolution, emotional development, and the like.
- The onsite services of a Child Behavioral Health Specialist can provide services critical to prevention, identification, and early intervention of child behavior problems. This specialist can make informal or formal observations of children onsite or in homes, and provide consultation to teachers and/or medical staff, and families.
- More in-depth, individual developmental intervention services such as physical therapy, occupational therapy, speech therapy, and/or play therapy or other age-appropriate counseling may also be made available onsite.
- Referrals to more intensive, individual, and family mental health services may be required to address serious child behavior or attachment problems.

Because SESS programs typically target young children, it may be more common for staff to encounter adult mental health issues than child ones, especially during infancy. SESS mental health services targeting adults may include:

- Training early childhood and primary health care staff regarding caregiver mental health issues and needs is equally important to training about infant and child mental health.
- Universally available education/prevention topic groups related to mental health issues may be offered to caregivers. These group topics will be guided by the interests of participants, but may include self-care and soothing techniques, crisis management, nonviolent problem-solving, conflict resolution, domestic violence awareness, communication skills, recognizing and coping with depression, women's health and nutrition and the like. Ongoing parent support groups may also be offered.
- Onsite adult Mental Health Specialists provide needed assessment and intervention. The immediate and accessible availability of such

services to caregivers, teachers, and/or medical staff may encourage service use and prevent the need to enter broader mental health systems. Services may include acute, short-term counseling services onsite or in the home to individuals, couples, and families.

- Referrals to more intensive, individual and family mental health and psychiatric services may be required to address serious adult symptoms and diagnoses.
- SESS staff can provide mental health treatment engagement and compliance support through ongoing contacts with family members and treatment agency staff.

d.) Family/Parenting Services. Effective parenting, including clear communication, appropriate limit setting, and a responsive and nurturing parent-child relationship can help foster the healthy development of children and protect them from behavioral and emotional difficulties (Belcher & Shinitzky, 1998; Center for Substance Abuse Prevention, 1998b; Resnick et al., 1997). Parents who are at-risk due to substance abuse and/or mental health difficulties may have more difficulty establishing and maintaining healthy relationships with their children and benefit from supports in this area. Prevention efforts must focus on education and skills training that will assist parents in supporting their children's social and emotional development (Kumpfer, 1998). Efforts focusing on the early parent-child relationship will help prevent future substance abuse as well as other health risk behavior such as violence, early sexual activity, and school dropouts (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999; Kumpfer, 1996).

There are many curriculum-based parenting programs available. Evaluation criteria and descriptions of effective programs can be found in Kumpfer (1999) and at the Strengthening America's Families Web site sponsored by the Office of Juvenile Justice and Delinquency Prevention (Center for Substance Abuse Prevention & Office of Juvenile Justice and Delinquency Prevention, 2000; Office of Juvenile Justice and Delinquency Prevention, 2000). Some global concepts often included in such programs include developmentally appropriate child behavior and expectations, child health and development, positive/appropriate discipline techniques, effective communication skills and parent-child interaction, structured play

activities, and building child self-esteem, social competence and life skills. Specific SESS activities related to family/parenting services may include:

- Educational and anticipatory guidance-based curriculums regarding parenting and child development may be delivered to parents in group or individual sessions onsite or in homes.
- In-home sessions may incorporate informal observation of the entire family, resulting in offering responsive support and modeling of appropriate parenting skills by SESS staff.
- Site-based groups or classes on parenting may go beyond simple educational groups to utilize a more therapeutic approach that incorporates group process and/or parent-child activities to process and demonstrate parenting skills.
- Open-ended and ongoing family/parenting support and/or advocacy groups may be appreciated by some parents. These groups can be open to all participants or may target specific groups such as fathers, grandmothers, young mothers, or alternate caregivers.
- Offering family recreation activities that are attended by SESS intervention staff and families provides an engaging context in which to observe family interactions and provide support and feedback in a natural and informal manner.
- Individual parenting-oriented counseling sessions focus on specific child behavior problems or developmental issues may also be needed by some parents. When issues are focused on parent-child relationship issues, interactional approaches such as videotaping and/or reviewing interactions with parents are useful therapeutic tools (e.g., Bernstein, Hans, & Percansky, 1991; McDonough, 1995; McDonough, 2000; Robert-Tissot, Cramer, Stern, Serpa, & et al, 1996; Sluckin, 1998).

C. INTERVENTION SUMMARY AND PRELIMINARY THEORY OF CHANGE

Stressful experiences during the formative years can affect brain development and place children at risk for developing a variety of cognitive, behavioral, and emotional difficulties (Fox, Calkins, & Bell, 1994; Schore, 1996; Spreen, Risser, & Edgell, 1995). The array of possible negative outcomes suggests that multiple services, including those related to substance abuse and mental health, should be made available early in a child's life. Primary health care and early childhood education settings represent potentially powerful settings in which to target and identify families with young children (Bernstein, Hans, & Percansky, 1991). The idea is to intervene as early as possible within the parent-child relationship, utilizing comprehensive, family-centered behavioral health services in a familiar and accessible setting. The parent-child relationship, especially in early childhood years, is viewed as a prime vehicle for bolstering child and family protective factors and preventing child behavioral and developmental problems. A major expected outcome or goal of intervention and prevention activities is to facilitate resiliency in young children and families affected by substance abuse and mental health issues. The original SESS sites developed a detailed conceptual model of change that described expected changes within the target populations and communities as a result of the service integration model (see Appendix F).

The idea is to intervene as early as possible within the parent-child relationship, utilizing comprehensive, family-centered behavioral health services in a familiar and accessible setting. The parent-child relationship, especially in early childhood years, is viewed as a prime vehicle for bolstering child and family protective factors and preventing child behavioral and developmental problems.

V

IDENTIFYING WHAT WORKS: AGENCY-BASED PROGRAM EVALUATION

The *Starting Early Starting Smart* (SESS) study was being conducted during a time when the value of social services is being questioned and major policy reforms affecting child and family services are taking place (e.g., privatization of child welfare and mental health services, use of managed care delivery models, TANF public assistance changes, and child welfare reform legislation such as PL 96-272 and PL 105-89). Outcome evaluations have become a critical part of building, funding, and sustaining early intervention programs.

This section is intended to serve as a guide for developing outcome evaluations that follow from the specific intervention package, community needs, and available resources of each individual agency and program. As in the approach described throughout, specific mandates regarding outcome domains and assessment tools are not made. Instead, examples of outcome indicators are provided to suggest potential domains and to guide agencies in selecting the key outcomes and measures appropriate to their specific interventions, settings, and populations.

A. GENERAL ISSUES IN DESIGNING AN EVALUATION

As stated, evaluation questions should be related to the specific program intervention activities being conducted. The program should have a clear vision of what the intervention goals are and these should be translated into measurable outcomes. It may be helpful to answer the question, "which skills/strengths/behaviors does your intervention seek to enhance and which problems does it seek to prevent?" The primary evaluation goals, as well as expected outcomes of the intervention, should be specifically elaborated and agreed upon by key program and evaluation staff.

Some thought should be given to the theory of change, or the process by which the intervention activities will lead to the desired or expected outcomes. This will often clarify the time frame in

which these changes are expected to take place, allowing them to be classified as short-term or long-term outcomes. For example, in an intervention aimed at improving parenting practices in order to increase child social skills, improvement in social skills (long-term) may not be seen by the end of the project. However, improvement of parenting practices (short-term) may be observable. Another example of a long-term outcome is increasing a family's financial self-sufficiency. Short-term outcomes that might relate to this long-term goal include participation in educational or vocational activities, arranging child care, and/or gaining job interview skills. Even shorter-term related outcomes might include obtaining a driver's license, enrolling in a GED or ESOL class, applying for child care vouchers, or applying to an educational/vocational program.

Once the key evaluation questions, short- and long-term outcomes, and mechanisms of change have been specified, the next step involves identification of the measures or assessment tools that are feasible, reliable, and culturally appropriate for the target population, and the least burden on participants and service providers. One source of potentially simple and inexpensive data collection includes program monitoring data already being collected systematically for billing, funding, or other reporting requirements. Specific information collected will vary by program requirements and procedures, but may include information about how many clients participate, the actual services provided to whom and how frequently, as well as some basic characteristics of the clients served (e.g., age, gender, ethnicity, income level). These data may be used to calculate dosage or intensity of services received by each participant. Each agency should assess the availability and utility of this sort of information within their setting, since it is useful to consider how existing data could be used and/or modified in the overall evaluation.

Completion of this evaluation design process will lead to the development of a logic model that will clearly illustrate major program evaluation goals and objectives, hypothesized mechanisms of change, the relationship between targeted short- and long-term outcomes, and measures.

B. POTENTIAL OUTCOME DOMAINS FOR EARLY INTERVENTION PROGRAMS

1. Child Development: Given the general goal of early intervention to enhance child mental, motor, social, emotional, and behavioral development, most early intervention evaluations include measures in this domain, administered either to participating children or their caregivers. Measures of the child's general developmental status typically include evaluation of current mental and motor functioning during infancy, global cognitive and language processing skills generally starting in toddlerhood, and school readiness indicators beginning with preschoolers. Social, emotional, and behavioral development is typically measured through observational and caregiver-report measures of functioning, which evaluate social-emotional regulation, behavior problems and competencies, and social skills. Within this domain, it is critical that the specific measures selected are culturally appropriate, especially with regard to age and language, while at the same time reflect the specific objectives of the program being delivered.

In addition to general physical health status, some programs consider specific areas of family health and safety such as general social support, conflict communication styles, domestic violence, and the incidence of child abuse and neglect.

2. Caregiver/Family Functioning: Because children develop in the context of families, caregiver and family functioning is closely linked to child development and is a commonly targeted outcome domain for early intervention programs. Measures include assessments of caregiver behavioral health status, such as the level of current psychological symptoms and patterns of substance use and abuse. In addition, parenting-role stress and skills are often targeted and measured with self-report inventories. Various observational rating systems and measures are also available to measure potential contributions of caregiver-child interaction, as well as the quality of the home environment to child developmental outcomes. (See the SESS Web sites referenced on the cover of this paper.)

3. Family Health and Safety: This category captures the expectation that early intervention programs may affect child and adult health outcomes, broadly defined to include aspects of health status and health care utilization. In addition to general physical health status, some programs consider specific areas of family health and safety such as general social support, conflict communication styles, domestic violence, and the incidence of child abuse and neglect.

4. Service Integration: A final but primary outcome domain in a SESS early intervention model focused on integrated services includes some measure of client access, utilization, and satisfaction with physical and behavioral health services. Within the context of evaluating this outcome, process data collection regarding the fidelity or adherence to the designed integrated intervention model is necessary. This may include collecting data on the types, duration, and dosage of services, as well as whether the interventions being provided match closely to what the program blueprint or logic model outlined.

5. Other Associated Outcomes: Several other family outcome domains can potentially be affected by early intervention programs, depending on program emphases. Many times demographic or descriptive information about specific areas of interest can be collected and utilized in program evaluation. Economic well-being of the family is one example for which programs might want to assess household income, caregivers' employment and educational status. Another example of an area that might be positively changed by early intervention is involvement in criminal activity, measured via specific crimes committed or by quantifying contact with the criminal justice system (e.g., arrests, convictions). While longitudinal program evaluations typically consider these outcomes for participating children as they make the transition to adulthood, some programs focus on this domain for caregivers.

C. MEASURING KEY OUTCOME DOMAINS

How one measures the success of a SESS effort depends upon the stage of implementation that the program is in and the funds available for evaluation (Jacobs, 1988). Exhibit 4 illustrates a sampling of some possible measures of early intervention program impacts in the first four broad outcome domains described above. Within each domain, we list a few of the common measures used in early intervention studies. These measures are often administered to caregivers in an interview format, and they focus on the child, the caregiver, or the family. However, some measures are administered directly with young children or incorporate observational rating systems of the family environment and interactions. Decisions about who administers the measures and how often will depend upon the measures selected, availability of the participants, and agency evaluation resources. The specific measures listed in Exhibit 4 are intended only to be illustrative of the types of indicators measured in each domain, rather than reflecting the full range of what might be available. This list is not exhaustive or obligatory, since each

program site must assess what evaluation measures will be realistic and appropriate to its specific domains of interest. An individual program's intervention and logic model, community needs, and agency resources may differ and will help determine what can realistically be used.

D. THE SESS NATIONAL CROSS-SITE EVALUATION

The evaluation of the twelve current SESS sites is guided by two primary research questions:

1. Will the integration of behavioral health services with a primary health care or early

EXHIBIT 4.
KEY OUTCOME DOMAINS AND INDICATORS: A SAMPLING OF POTENTIAL MEASURES

Outcome Domains and Indicators	Potential Measures
I. Child Development	
A. Mental and Motor Development	▫ Bayley Scales of Infant Development, Second Edition (Mental and Motor Scales) (Baley, 1993) ▫ Early Learning Accomplishment Profile (E-LAP) (Glover, 1995)
B. Global Cognitive Skills	▫ Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) (Wechsler, 1989) (selected subtests may be given)
C. Language Processing Skills	▫ Clinical Evaluation of Language Fundamentals—Preschool Quick Test (CELF-P Quick) (Wiig, Secord, & Semel, 1992) ▫ McArthur Communicative Developmental Inventories (CDI) Toddler Form (Fenson, Larry, & Others, 1993) (selected subtests may be given) ▫ Peabody Picture Vocabulary Test (PPVT) (Dunn & Dunn, 1981)
D. School Readiness Indicators	▫ Academic Rating Scale of the Fall or Spring Kindergarten Questionnaire of the Early Childhood Longitudinal Study (ARS) ▫ Developmental Indicators for the Assessment of Learning-Revised (DIAL-R) (Mardell-Czudnowski & Goldenberg, 1990) ▫ Early Screening Inventory (ESI) (Meisels, Marsden, Wiske, & Henderson, 1997) ▫ Head Start Family and Child Experiences Survey (FACES) ▫ Vermont Kindergarten Teacher Questionnaire (Gorman & Burns, 2000)
E. Behavioral and Emotional Development	▫ Achenbach's Child Behavior Checklist 2-3 (CBCL) (Achenbach, 1992) ▫ Bayley Scales of Infant Development, Second Edition (Behavior Rating Scale) (Bayley, 1993) ▫ Devereaux Early Childhood Assessment—Parent and Teacher Versions (LeBuffe & Naglieri, 1999) ▫ Infant-Toddler Symptom Checklist (DeGangi, Poisson, Sickel, & Wiener, 1995) ▫ Preschool Kindergarten Behavior Scales (PKBS) (Merrett, 1994)

Outcome Domains and Indicators	Potential Measures
II. Caregiver/Family Functioning	
A. Caregiver Behavioral Health Status	▪ Addiction Severity Index (ASI) (McLellan et al., 1990) ▫ Beck Depression Inventory (BDI) (Beck & Steer, 1987) ▫ Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1999) ▫ CAGE (Cut down, Annoyed, Guilty, Eye opener) Questionnaire (a 4-item brief screener for alcohol/drug use) from the Health and Lifestyle Survey ▫ Substance Abuse Subtle Screening Inventory-3 (SASSI-3) (Miller, 1994)
B. Parenting Role Stress and Skills	▫ Adult/Adolescent Parenting Inventory (AAPI) (Bavolek & Keene, 1999) ▫ Parent-Child Relationship Inventory (PCRI) (Gerard, 1994) ▫ SESS Parental Discipline Methods Interview (adapted from Webster-Stratton's Parenting Practices Interview and the Kansas Discipline Methods Questionnaire) ▫ Parenting Dimensions Inventory (Slater & Power, 1987) ▫ Parenting Practices Questionnaire (Strayhorn & Weidman, 1988) ▪ Parenting Stress Index (PSI) (Abidin, 1990)
C. Caregiver-Child Interaction	▫ Nursing Child Assessment Satellite Training (NCAST) Feeding Scale (Barnard, 1994a) ▫ Nursing Child Assessment Satellite Training (NCAST) Teaching Scale (Barnard, 1994b) ▫ National Institute on Child Health and Development Scales (NICHD) (Early Child Care Research Network, 1993) ▫ Parent-Child Observational Guide (PCOG) (developed by V. Bernstein and the SESS Steering Committee's Parent-Child Interaction Workgroup)
D. Quality of Home and Caregiving Environment	▫ Home Observation for Measurement of the Environment (HOME) (Caldwell & Bradley, 1984)
III. Family Health and Safety	
A. Child Health	▫ SESS Physical Health Questionnaire—Infant and Child Versions
B. Caregiver Health	▫ Short Form Health Survey (This has various lengths, including the SF12, SF20, SF36.) (Stewart, Hays, & Ware, Jr., 1988)

EXHIBIT 4 (continued).
KEY OUTCOME DOMAINS AND INDICATORS: A SAMPLING OF POTENTIAL MEASURES

Outcome Domains and Indicators	Potential Measures
III. Family Health and Safety (continued)	
C. Family Conflict Management and Communication	▫ Conflict Tactics Scale-Revised (CTS-R) (Straus, 1989; Straus, Hamby, Boney-McCoy, & Sugarman, 1996)
D. Parenting Role Stress and Skills	▫ Multidimensional Scale of Perceived Social Support (Zimet, Powell, Farley, Werkman, & Berkoff, 1990)
E. Child Maltreatment	▫ Child Abuse Potential Inventory (CAPI) (Milner & Wimberley, 1979) ▫ Verified Child Maltreatment and/or Injury Reports
IV. Service Integration	
A. Access, Utilization, and Satisfaction with Services	▫ SESS Service Access, Utilization, and Satisfaction (SAUS) (data collection instrument will be made available on the SESS Web site)
B. Service Model Fidelity	▫ Measures of dosage, duration, intensity and adherence to the program logic model, and/or practice protocols ▫ Consumer and staff satisfaction and needs surveys or focus groups

childhood service site lead to higher rates ofz entry into prevention, early intervention, orz treatment of children/families identified as inz need of behavioral health services, as comparedz to children/families served in primary healthz care or early childhood service settings wherez no such integration of services takes place?z

2. Will the integration of behavioral healtha services within a primary health care or earlya childhood service site promote and sustaina measurable improvements (social, emotional,a nd cognitive) in children and families served,a compared to children and families in primarya health care or early childhood service settingsa where no such integration takes place?a

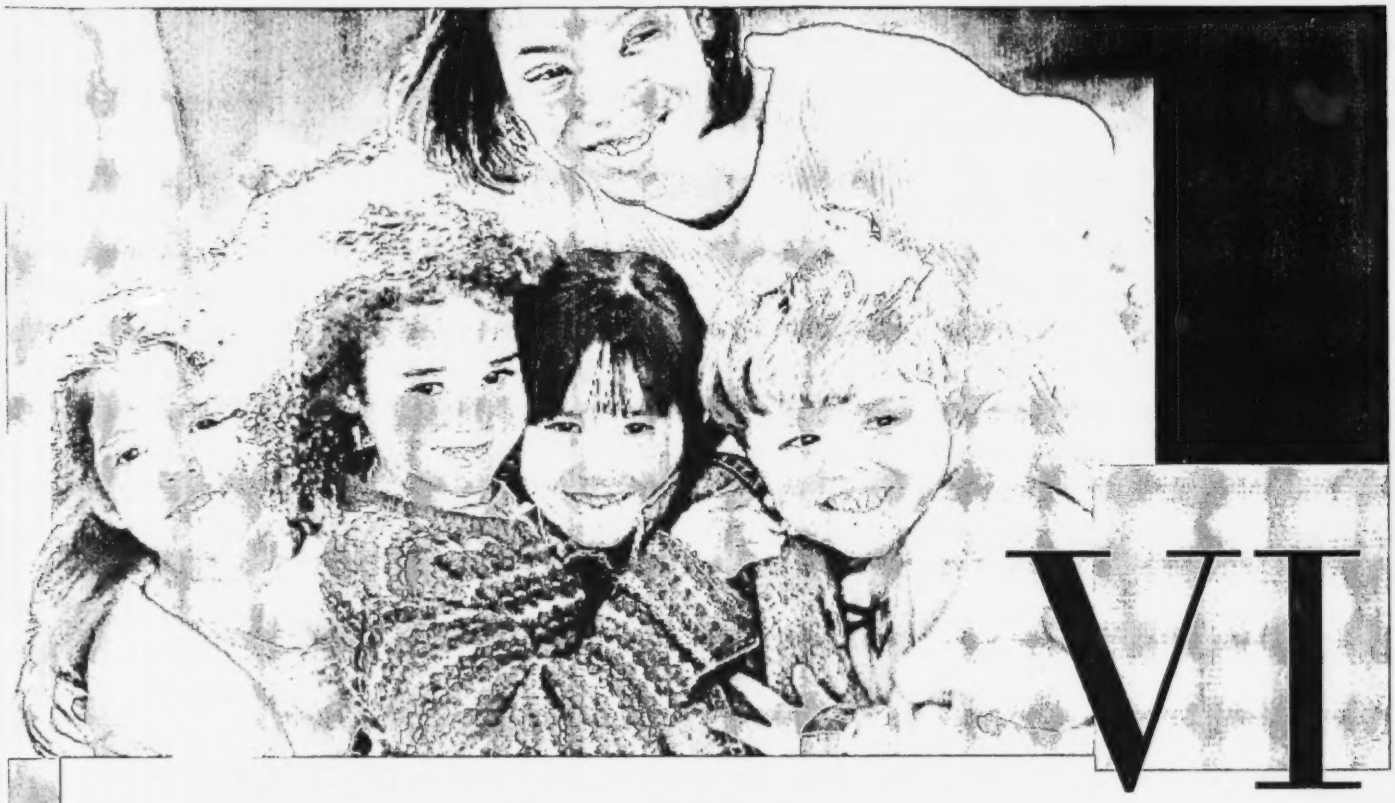
Examples of key outcome domains are listeda below, but for a complete list and description ofa this information, please refer to other resourcesa (*Starting Early Starting Smart* Steering Committee,a 1998).a

Child Domains:

- ☒ Child attachment/bonding to parent/caregiverz
- ☐ Behavioral competence (e.g., age appropriatea self-regulation and conflict resolution skills)a
- ☐ Social competence (e.g., developmentallya ppropriate play skills)a
- ☐ School readiness, such as language anda cognitive developmenta

Parent/Caregiver Domains:

- ☐ Substance abuse and psychological functioninga
- ☐ Planning and life organization skillsa
- ☐ Parenting skillsa
- ☐ Cohesive family functioning (e.g., absence ofa buse/violence)a
- ☐ Employment/education statusa



VI

SUMMARY AND CONCLUSIONS

This paper has described the *Starting Early Starting Smart* (SESS) approach, an early intervention program that has been developed in the context of the national, multi-site program and evaluation funded by the Substance Abuse and Mental Health Services Administration and Casey Family Programs. The emphasis in SESS is on the integration of behavioral health services into easily accessible, non-threatening settings where caregivers naturally and regularly take their young children. Current SESS sites are based in primary pediatric health care and early childhood educational settings. The major goal of this early intervention service integration approach is to increase access and utilization of needed behavioral health services by families with young children, thereby improving child and family outcomes and resiliency. The focus is on providing and coordinating prevention and early intervention activities for young children, their adult caregivers and their siblings to strengthen the entire family. Throughout these activities, the SESS model advocates a relationship-oriented approach at all systems levels, including parent-child, family-staff, staff-agency, and agency-agency interactions.

In addition to describing the SESS philosophy, a general overview of the implementation and planning processes was provided:

1. A comprehensive community assessment that captures information regarding the resources and needs of both the target population and service providers of the community.
2. Facilitating family involvement and participatory planning.
3. Developing a SESS collaborative that includes a range of stakeholders, including families, service providers, agencies, and the community-at-large.
4. Providing staff support, training, and supervision to facilitate retention of high-quality staff and program success.

Care coordinators are a central contact for families, but only one part of a multidisciplinary intervention team. At a minimum, SESS programs should have available within each behavioral health service area ongoing screening, assessment, and referral options.

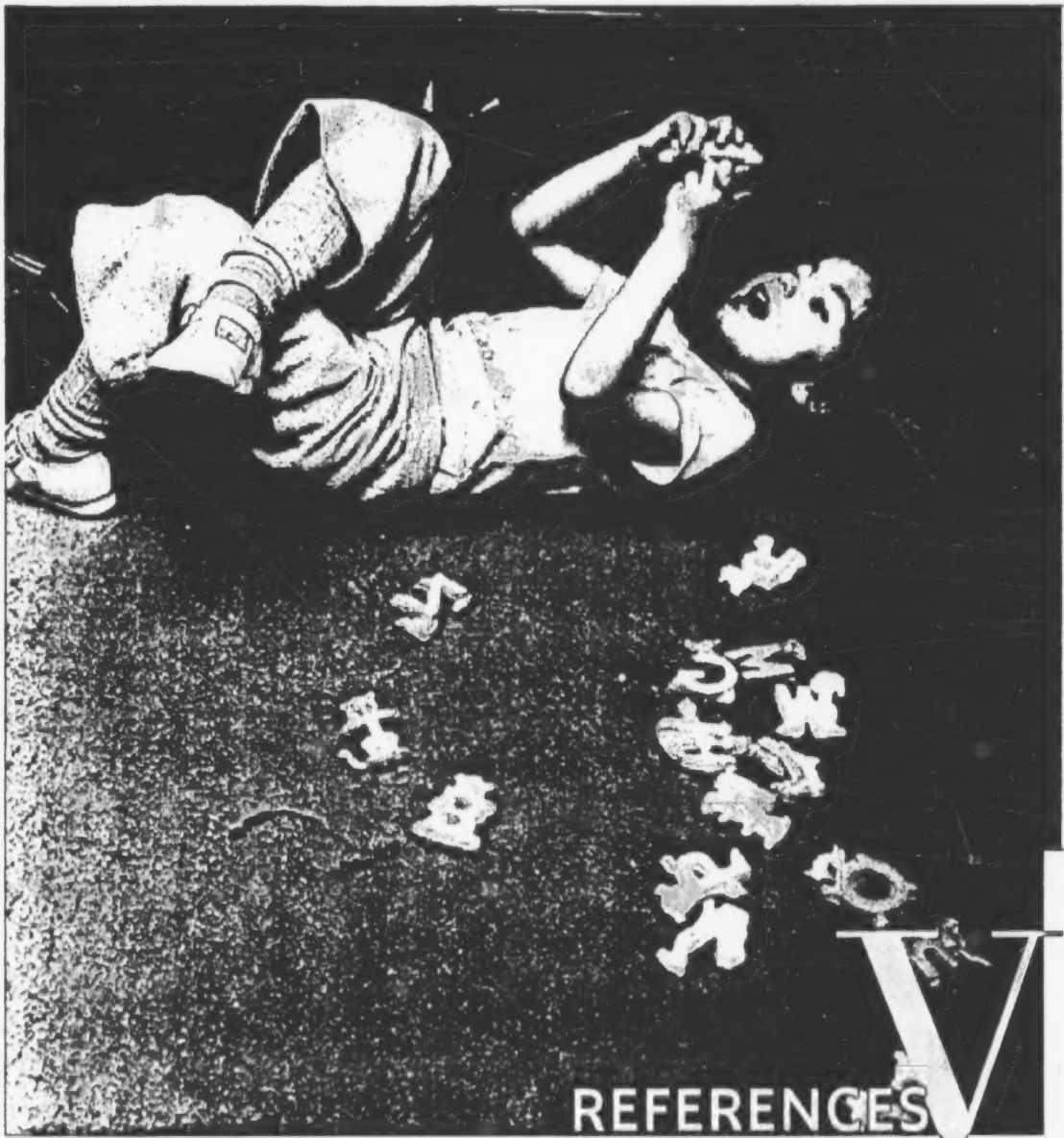
5. Recruiting and retaining SESS participants ina intervention services.a

6. Planning for sustainability from the conceptiona of programs forward.a

There is no single, universally imposed SESSa intervention protocol, but rather this must bea developed on a site-by-site basis to tailor the overalla program plan to the specific population, setting,a nd community served, within the guidelines of thea key SESS philosophical principles. SESS servicesa should be comprehensive and responsive acrossa time, culturally competent, strength-based, anda family-centered.a

Tying behavioral health services together in a service integration approach is the provision ofa family support, advocacy, and care coordinationa that addresses medical, educational, and basica needs, as well as to coordinate behavioral healtha nd other services for families. Care coordinatorsa re a central contact for families, but only one parta of a multidisciplinary intervention team. At a minimum, SESS programs should have availablea within each behavioral health service area ongoinga screening, assessment, and referral options. Ina ddition, some direct intervention activities in eacha rea should be offered, although programs maya choose from a progression of options that vary ina intensity and duration depending on the needs ofa the target population and setting.a

Similar to the flexible approach to selectinga intervention components, the development of a program's logic model and evaluation strategiesa must be tailored to fit the specific program goalsa nd intervention design, as well as the agency anda community needs and resources. Several majora outcome domains and measures of potentiala interest to early intervention programs werea highlighted, including child development, caregiver/a family functioning, family health and safety, servicea integration, and other associated outcomes. Ina conclusion, there are no absolute or perfecta solutions to designing a SESS early interventiona program, but this paper has set forth some generala guiding principles, as well as valid options anda choices to enable communities to begin thea process of developing a tailored SESS approacha that can work best in the context of a particulara setting, population, and community.a



VII. REFERENCES

Abidin, R. R. (1990). *Parenting Stress Index Manual.* Odessa, FL: Psychological Assessment Resources.

Achenbach, T. M. (1992). *Manual for the Child Behavior Checklist/2-3 and 1992 Profile.* Burlington, VT: University of Vermont Department of Psychiatry.

Barnard, K. (1994a). *Nursing Child Assessment Satellite Training (NCAST) Feeding Scale.* Seattle, WA: NCAST Programs.

Barnard, K. (1994b). *Nursing Child Assessment Satellite Training (NCAST) Teaching Scale.* Seattle, WA: NCAST Programs.

Bass, L. & Jackson, M. S. (1997). A study of drug abusing African-American pregnant women. *Journal of Drug Issues, 27,* 659-671.

Bavolek, S. & Keene (1999). *The adult-adolescent parenting inventory (AAPI II) administration handbook.* Park City, UT: Family Development Resources.

Bayley, N. (1993). *Bayley Scales of Infant Development: Manual.* (2nd ed.) San Antonio, TX: The Psychological Corporation.

Beck, A. T. & Steer, R. A. (1987). *Beck Depression Inventory.* San Antonio, TX: Harcourt, Inc.

Belcher, H. M. & Shinitzky, H. E. (1998). Substance abuse in children: prediction, protection, and prevention. *Archives of Pediatrics & Adolescent Medicine, 152,* 952-960.

Berg, I. K. (1994). *Family-based services.* New York, NY: Norton & Co., Inc.

Bernstein, V. J., Hans, S. L., & Percansky, C. (1991). Advocating for the young child in need through strengthening the parenting-child relationship. *Journal of Clinical Child Psychology, 20,* 28-41.

Brounstein, P. J. & Zweig, J. M. (1999). *Understanding substance abuse prevention: Toward the 21st century: A primer on effective programs.* Rockville, MD: U.S. Government Printing Office.

Budney, A. J. & Higgins, S. T. (1998). A community reinforcement approach: treating cocaine addiction. *Therapy Manuals for Drug Addiction.* (NIH Publication No. 98-4309). Bethesda, MD: U.S. Department of Health and Human Services.

Caldwell, B. M. & Bradley, R. H. (1984). *Manual for the Home Observation for Measurement of the Environment (H.O.M.E.).* (Revised Edition ed.) Little Rock, AR: University of Arkansas.

Carroll, K. M. (1998). A cognitive-behavioral approach: treating cocaine addiction. *Therapy Manuals for Drug Addiction.* (NIH Publication No. 98-4308). Bethesda, MD: National Institute on Drug Abuse.

Carroll, K. M. (2000). *Approaches to drug abuse counseling.* (NIH Publication No. 00-4151). Bethesda, MD: National Institute on Drug Abuse.

Carten, A. J. (1996). Mothers in recovery: rebuilding families in the aftermath of addiction. *Social Work, 41,* 214-223.

Catalano, R. F., Haggerty, K. P., Gainey, R. R., & Hoppe, M. J. (1997). Reducing parental risk factors for children's substance misuse: Preliminary outcomes with opiate-addicted parents. *Substance Use and Misuse, 32,* 699-721.

Center for Substance Abuse Prevention (1993). Guidelines for assessing cultural competence. In *The Fact Is...* (February).

Center for Substance Abuse Prevention (1998b). Parenting is prevention: Resource guide. Washington, DC: U.S. Government Printing Office.

Center for Substance Abuse Prevention (1998a). What works in prevention? *Prevention Pipeline, 12.*

Center for Substance Abuse Prevention & Office of Juvenile Justice and Delinquency Prevention (2000). *Strengthening America's Families: Model family programs for substance abuse and delinquency prevention.* Rockville, MD: U.S. Department of Health and Human Services.

Center for Substance Abuse Prevention (2000). Center for Substance Abuse Prevention (Web site). (Online). Available: http://www.samhsa.gov/csap/index.html.

Center for Substance Abuse Prevention (2001). Guidelines for assessing cultural competence (Web site). (Online). Available: http:www.samhsa.gov/2000archive/grants/content2000/9appd.html.

Center for Substance Abuse Treatment (1994). Practical approaches in the treatment of women who abuse alcohol and other drugs. (DHHS Publication No. SMA 94-3006). Rockville, MD: U.S. Government Printing Office.

Closser, M. H. & Blow, F. C. (1993). Recent advances in addictive disorders. Special populations. Women, ethnic minorities, and the elderly. *Psychiatric Clinics of North America, 16*, 199-209.

COSMOS (2001). *Promises to keep: the technical tools of partnership and collaboration.* (Tentative title.) Unpublished manuscript from Collaborations to Integrate Services Toolkit Product #4.

Cross, T. Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed. Georgetown University Development Center, National Technical Assistance Center for Children's Mental Health.

Dakof, G., Quille, T., Szapocznik, J., Tejeda, M., Alberga, L., and Bandstra, E. S. *Engaging cocaine dependent mothers into drug abuse treatment.* Unpublished manuscript, University of Miami School of Medicine, Coral Gables, FL.

de Shazer, S. (1985). *Keys to solution in brief therapy.* New York, NY: W.W.Norton.

de Shazer, S., Berg, I.K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: focused solution development. *Family Process, 25*, 207-222.

DeGangi, G. A., Poisson, S., Sickel, R. Z., & Wiener, A. S. (1995). *Infant/Toddler Symptom Checklist: a screening tool for parents.* Tucson, AZ: Therapy Skill Builders.

Dennis, D. L., Steadman, H. J., & Cocozza, J. J. (2000). The impact of federal systems integration initiatives on services for mentally ill homeless persons. *Mental Health Services Research, 2*, 165-174.

Derogatis, L. R. & Spencer, P. M. (1999). The Brief Symptom Inventory: Administration, scoring, and procedures manual. Baltimore, MD: Clinical Psychometric Research, Inc.

Downey, G. & Coyne, J. (1990). Children of depressed parents: An integrative review. *Psychological Reports, 108*, 50-76.

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*, 589-608.

Dunn, L. M. & Dunn, L. M. (1981). *Peabody Picture Vocabulary Test-Revised.* Circle Pines, MN: American Guidance Service.

Early Child Care Research Network (1993). *NICHD mother-child interaction scales.*

Etheridge, R. M. & Hubbard, R. L. Conceptualizing and assessing treatment structure and process in community-based drug treatment programs. *Substance Use and Misuse* (in press).

Farkas, K. J. & Parran, T. V., Jr. (1993). Treatment of cocaine addiction during pregnancy. *Clinics In Perinatology, 20*, 29-45.

Federation of Families for Children's Mental Health (2001). *A guide for family involvement: SESS family strengths institute.* Washington, DC: Author. (Also see www.casey.org/projects.htm#sess or www.samhsa.gov.)

Fenson, L., Dale, P.S., Reznick, J., Thal, D., Steven, Bates, E., Hartung, J.P., Pethick, S., and Reilly, J.S. (1993). *McArthur Communicative Developmental Inventories (CDI) Toddler Form.* San Diego, CA: Singular Publishing Group.

Finkelstein, N. (1996). *Using the relational model as a context for treating pregnant and parenting chemically dependent women.* New York, NY: Haworth Press.

Fox, N., Calkins, S., & Bell, M. (1994). Neural plasticity and development in the first two years of life: evidence from cognitive and socioemotional domains of research. *Development & Psychopathology, 6*, 677-696.

Gelfand, D. M. & Teti, D. M. (1990). The effects of maternal depression on children. *Clinical Psychology Review, 10*, 329-353.

Gerard, A. (1994). *Parent-Child Relationship Inventory (PCRI) Manual.* Los Angeles, CA: Western Psychological Services.

Glisson, C. & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22,* 401-421.

Glover, M. E. (1995). *The Early Learning Accomplishment Profile (E-LAP) for Young Children Birth to 36 Months.* (Revised ed.) Lewisville, NC: Kaplan Press.

Gorman, K. S., & Burns, C. E. (June, 2000). Final report: A multi-part assessment of kindergarten readiness. State of Vermont Agency of Health and Human Services Planning Division.

Grover, P. L (1998). Preventing substance abuse among children and adolescents: Family-centered approaches. *Prevention Enhancement Protocols System, 2.* (DHHS Publication No. SMA 3224-FY 98). Rockville, MD: U.S. Government Printing Office.

Hammen, C. (1992). Life events and depression: The plot thickens. *American Journal of Community Psychology, 20,* 179-193.

Hammen, C. L., Adrian, C., Gordon, D., Burge, D., Jaenicke, C., & Hiroto, D. (1987). Children of depressed mothers: Maternal strain and symptom predictors of dysfunction. *Journal of Abnormal Psychology, 96,* 190-198.

Hawkins, J. D., Catalano, R. F., Kosterman, R., Abbott, R., & Hill, K. G. (1999). Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatrics & Adolescent Medicine, 153,* 226-234.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychological Bulletin, 112,* 64-105.

Henggler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M., & Cunningham, P. B. (1998). *Multi-systemic treatment of antisocial behavior in children and adolescents.* New York, NY: Guilford.

Howell, E. M., Heiser, N., & Harrington, M. (1999). A review of recent findings on substance abuse treatment for pregnant women. *Journal of Substance Abuse Treatment, 16,* 195-219.

Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11,* 261-278.

Hughes, H. M. Research concerning children of battered women: clinical implications (in press). In R. Geffner, S. B. Sorensen, & P. K. Lundberg-Love (Eds.), *Violence and sexual abuse at home: current issues, interventions and research in spousal battering and child maltreatment.* Binghamton, NY: Haworth.

Jacobs, F. H. (1988). The five-tiered approach to evaluation: context and implementation. In H.B.Weiss & F. H. Jacobs (Eds.), *Evaluating family programs* (pp. 37-68). New York, NY: Aldine de Gruyter.

Jaffe, P. G., Wolfe, D., Wilson, S. K., & Zak, L. (1985). Critical issues in the assessment of children's adjustment to witnessing family violence. *Canada's Mental Health, 33,* 15-19.

Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142,* 1259-1264.

Knitzer, J. (2000). Promoting resilience: Helping young children and parents affected by substance abuse, domestic violence, and depression in the context of welfare reform. *Children and Welfare Reform, Issue Brief 8.* New York, NY: National Center for Children in Poverty.

Koyanagi, C. & Feres-Merchant, D. (2000). For the long haul: maintaining systems of care beyond the federal investment. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume III.*

Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Kretzman, J. P. & McKnight, J. L. (1993). *Building communities from the inside out: a path toward finding and mobilizing a community's assets.* Chicago, IL: ACTA Publications.

Kumpfer, K. L. (1996). Effectiveness of a culturally tailored, family-focused substance abuse program: The Strengthening Families program. *National Conference on Drug Abuse Prevention Research: Presentations, Papers, and Recommendations.* National Institute on Drug Abuse, Washington, DC.

Kumpfer, K. L. (1997). What works in the prevention of drug abuse: Individual, school and family approaches. *Resource Papers for the Secretary's Youth Substance Abuse Initiative.* Paper presented at the Regional Technical Assistance Workshop.

Kumpfer, K. L. (1998). Links between prevention and treatment for drug abusing women and their children. In C.L.Wetherington & A. B. Roman (Eds.), *Drug addiction research and the health of women* (pp. 417-437). Rockville, MD: U.S. Department of Health and Human Services.

Kumpfer, K. L. (1999). *Strengthening America's Families: exemplary parenting and family strategies for delinquency prevention.* User's guide prepared under grant from Office of Juvenile Justice and Delinquency Prevention.

LeBuffe, P. A. & Naglieri, J. A. (1999). *Devereux Early Childhood Assessment (DECA).* Odessa, FL: Psychological Assessment Resources, Inc.

Lee, C. M. & Gotlib, I. H. (1989b). Clinical status and emotional adjustment of children of depressed mothers. *American Journal of Psychiatry, 146,* 478-483.

Lee, C. M. & Gotlib, I. H. (1989a). Maternal depression and child adjustment: A longitudinal analysis. *Journal of Abnormal Psychology, 98,* 78-85.

Lee, C. M. & Gotlib, I. H. (1991). Adjustment of children of depressed mothers: a 10-month follow-up. *Journal of Abnormal Psychology, 100,* 473-477.

Leshner, A. I. (1998b). Director's column: Gender matters in drug abuse research. *NIDA Notes, 13,* 3-4.

Leshner, A. I. (1998a). Foreword. In C.L.Wetherington & A. B. Roman (Eds.), *Drug addiction research and the health of women* (pp. iii-iv). Rockville, MD: National Institutes of Health.

Leshner, A. I. (1999). Science-based views of drug addiction and its treatment. *Journal of the American Medical Association, 282,* 1314-1316.

Mardell-Czudnowski, C. & Goldenberg, D. S. (1990). *DIAL-R: Developmental Indicators for the Assessment of Learning.* (AGS ed.) Circle Pines, MN: American Guidance Service.

Markou, A., Kosten, T. R., & Koob, G. F. (1998). Neurobiological similarities in depression and drug dependence: a self-medication hypothesis. *Neuropsychopharmacology, 18,* 135-174.

Maslow, A. H. (1970). *Motivation and Personality.* (2nd ed.) New York, NY: Harper and Row.

McDonough, S. C. (1995). Promoting positive early parent-infant relationships through interaction guidance. *Child and Adolescent Psychiatric Clinics of North America, 4,* 661-672.

McDonough, S. C. (2000). Interaction guidance: an approach for difficult-to-engage families. In C.H.J. Zeanah (Ed.), *Handbook of Infant Mental Health* (2nd ed., pp. 485-493). New York, NY: The Guilford Press.

McLellan, A., Parikh, G., Bragg, A., Cacciola, J., Fureman, B., & Incmikoski, R. (1990). *Addiction Severity Index-Administration Manual Fifth Edition.* Penn, VA: Center for Studies of Addiction.

Meisels, S. J., Marsden, D. B., Wiske, M. S., & Henderson, L. W. (1997). *Early Screening Inventory (ESI).* Ann Arbor, MI: Rebus, Inc.

Mercer, D. E. and Woody, G. E. (9/1999). An individual drug counseling approach to treat cocaine addiction: The collaborative cocaine treatment study model. *Therapy Manuals for Drug Addiction.* (NIH Publication No. 99-4380). Bethesda, MD: U.S. Department of Health and Human Services.

Merrett, K. M. (1994). *Preschool and Kindergarten Behavior Scales (PKBS).* Brandon, VT: Clinical Psychology Publishing Company, Inc.

Mertin, P. G. (1992). An adaption of the conflict tactics scales. *Australian Journal of Marriage and Family, 13,* 166-169.

Miller, G. (1994). *Substance Abuse Subtle Screening Inventory (SASSI).* Springsville, IN: SASSI Institute.

Miller, S.D. (2000). Description of the solution-focused brief therapy approach to problem drinking. *Approaches to Drug Abuse Counseling.* (NIH publication No. 00-4151). Bethesda, MD: National Institute on Drug Abuse.

Miller, W. R. (1996). Motivational interviewing: research, practice, and puzzles. *Addictive Behaviors, 21,* 835-842.

Milner, J. S. & Wimberley, R. C. (1979). An inventory for the identification of child abusers. *Journal of Clinical Psychology, 35,* 95-100.

Mrazek, P. J. & Haggerty, R. J. (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research.* Washington, DC: National Academy Press.

National Institute on Drug Abuse (1999). Principles of drug addiction treatment: a research-based guide. (NIH Publication No. 00-4180). Rockville, MD: Author.

National Institute on Drug Abuse (2000). National Institute on Drug Abuse (Web site). (Online). Available: http://www.nida.nih.gov.

O'Hanlon, B. & Weiner-Davis, M. (1989). *In Search of Solutions: A New Direction in Psychotherapy.* (1st ed.) New York, NY: W.W. Norton.

Office of Juvenile Justice and Delinquency Prevention (2000). Strengthening America's Families (Web site). (Online). Available: http://www.strengtheningfamilies.org.

Pecora, P. J., Bernstein, V., & Springer, J. F. (1999). *Proposal for the Smith Richardson Foundation: Need for Integrated Services.*

Phillips, J. & Springer, J. F. (2000). *Implementation of Community Interventions: Lessons Learned.* Unpublished manuscript, EMT Associates, Inc., Folsom, CA.

Prochaska, J. O. & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W.R. Miller & N. Heather (Eds.), *Treating Addictive Behaviors* (pp. 3-27). New York, NY: Plenum Press.

Prochaska, J. O. & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), *Progress in Behavior Modification* (pp. 184-214). Sycamore, IL: Sycamore Press.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

Quille, T. and Dakof, G. (1999). *Helping Drug Addicted Mothers Enter and Remain in Treatment: An Intervention Manual.* Unpublished manual, University of Miami School of Medicine, Coral Gables, FL.

Ramlow, B. E., White, A. L., Watson, D. D., & Leukefeld, C. G. (1997). The needs of women with substance use problems: An expanded vision for treatment. *Substance Use and Misuse, 32*, 1395-1404.

Reed, B. G. (1985). Drug misuse and dependency in women: the meaning and implications of being considered a special population or minority group. *International Journal of Addictions, 20*, 13-62.

Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J., Tabor, J., Beuhring, T., Sieving, R.E., Shew, M., Ireland, M., Bearinger, L.H., & Udry, J.R. (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278*, 823-832.

Robert-Tissot, C., Cramer, B., Stern, D. N., Serpa, S. R., Bachmann, J.P., Palacio-Espasa, F., Knauer, D., de Muralt, M., Berney, C., & Mendiguren, G. (1996). Outcome evaluation in brief mother-infant psychotherapies: report on 75 cases. *Infant Mental Health Journal, 17*, 97-114.

Rosenbaum, M. and Murphy, S. (1996). Women and addiction: Process, treatment, and outcome. *The Collection and Interpretation of Data From Hidden Populations, NIDA Monograph 98.* (DHHS Publication No. ADM 90-1678). Washington, DC: U.S. Government Printing Office.

Saulnier, C. F. (1996). African American women in an alcohol intervention group: Addressing personal and political problems. *Substance Use and Misuse, 31*, 1259-1278.

Schliebner, C. T. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment, 11*, 511-515.

Schore, A. N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development & Psychopathology, 8*, 59-87.

Slater, M. A. & Power, T. G. (1987). Multidimensional assessment of parenting in single-parent families. In J.P. Vincent (Ed.), *Advances in Family Intervention, Assessment, and Theory* (pp. 197-228). Greenwich, CT: JAI Press.

Sloboda, Z. and David, S. L. (1997). Preventing drug use among children and adolescents. (NIH Publication No. 97-4212). Washington, DC: U.S. Government Printing Office.

Sluckin, A. (1998). Bonding failure: "I don't know this baby, she's nothing to do with me." *Clinical Child Psychology and Psychiatry, 3*, 11-24.

Spreen, O., Risser, A. T., & Edgell, D. E. (1995). *Developmental Neuropsychology.* New York, NY: Oxford University Press.

Starting Early Starting Smart Steering Committee (1998). *Starting Early Starting Smart Phase One Report.*

Stewart, A. L., Hays, R. D., & Ware, J. E., Jr. (1988). The MOS short-form general health survey. Reliability and validity in a patient population. *Medical Care, 26*, 724-735.

Stocker, S. (1998). Research findings: Men and women in drug abuse treatment relapse at different rates and for different reasons. *NIDA Notes, 13.*

Stoneman, Z., Brody, G. H., & Burke, M. (1989). Marital quality, depression, and inconsistent parenting: relationship with observed mother-child conflict. *American Journal of Orthopsychiatry, 59,* 105-117.

Straus, M. A. (1989). *Conflict Tactics Scales.* Durham, NH: Family Research Laboratory, University of New Hampshire.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2) development and preliminary psychometric data. *Journal of Family Issues, 17,* 283-316.

Strayhorn, J. M. & Weidman, C. S. (1988). A Parent Practices Scale and its relation to parent and child mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 613-618.

Szapocznik, J. (1997). Cultural competency and program implementation. Keynote address presented at Third National Training Conference on Strengthening America's Families, Washington, DC.

Szapocznik, J., Perez-Vidal, A., Brickman, A. L., Foote, F. H., Santisteban, D., Hervis, O., & Kurtines, W. M. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56,* 552-557.

U.S. Department of Health and Human Services (1999). *Substance Abuse A National Challenge: Prevention, Treatment and Research at HHS.*

U.S. Department of Health and Human Services (2000). Substance Abuse. *Healthy People 2010.*

Walter, J. L. & Peller, J. E. (1992). *Becoming Solution Focused in Brief Therapy.* New York, NY: Brunner/Mazel.

Wechsler, D. (1989). *Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R).* San Antonio, TX: Psychological Corporation.

Western Regional Center for the Application of Prevention Technologies (2000). *Building a successful prevention program: Guiding principles and best practices* (Web site). (Online). Available: http://www.open.org/~westcapt/bestprac.htm.

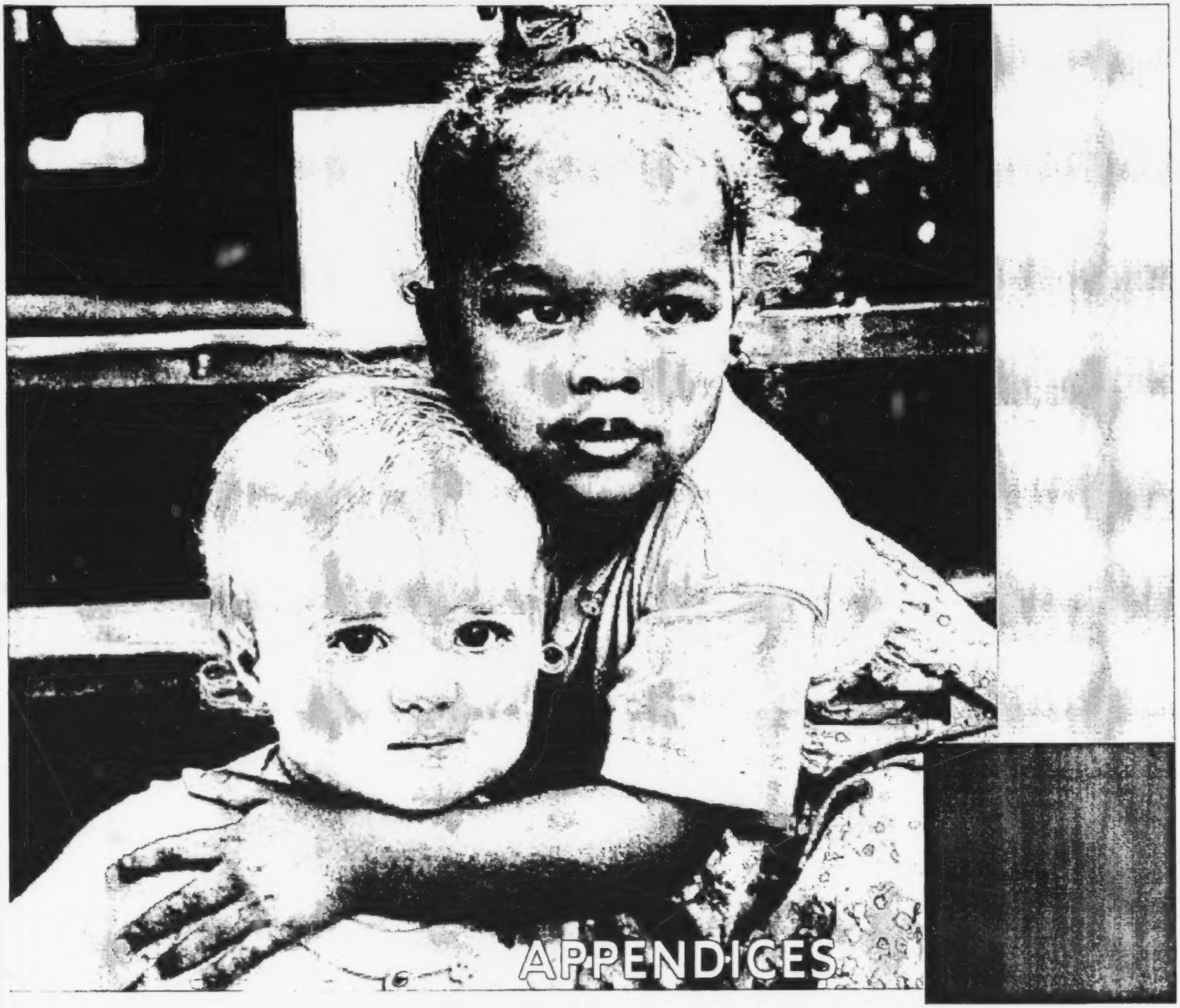
Wiig, E., Secord, W., & Semel, E. (1992). *Clinical Evaluation of Language Fundamentals - Preschool Quick Test (CELF-P Quick).* New York, NY: The Psychological Corporation.

Wolfe, D. A., Jaffe, P. G., Wilson, S. K., & Zak, L. (1985). Children of battered women: The relation of child behavior to family violence and maternal stress. *Journal of Consulting and Clinical Psychology, 53,* 657-665.

Wolfe, D. A., Jaffe, P. G., Wilson, S. K., & Zak, L. (1988). A multivariate investigation of children's adjustment to family violence. In G.T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. A. Straus (Eds.), *Family Abuse and Its Consequences* (pp. 228-243). Beverly Hills: Sage Publications.

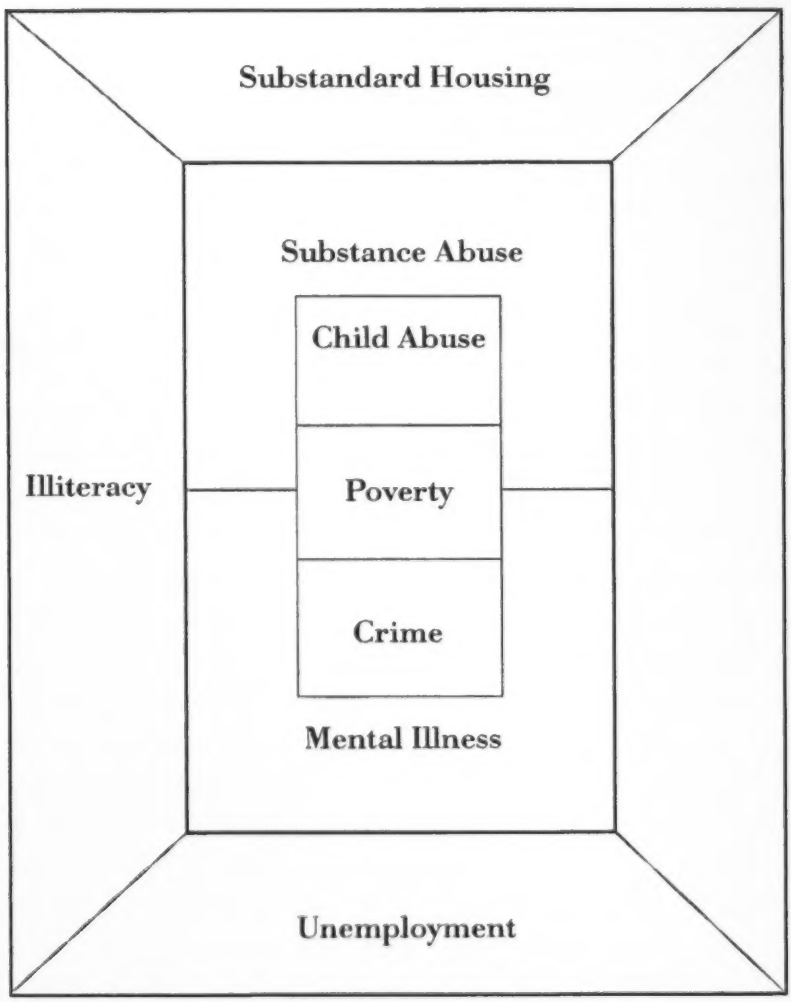
Zimet, G. D., Powell, S. S., Farley, G. K., Werkman, S., & Berkoff, K. A. (1990). Psychometric characteristics of the Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment, 55,* 610-617.

Zimmerman, T. S., Jacobsen, R. B., MacIntyre, M., & Watson, C. (1996). Solution-focused parenting groups: an empirical study. *Journal of Systemic Therapies, 15,* 12-25.

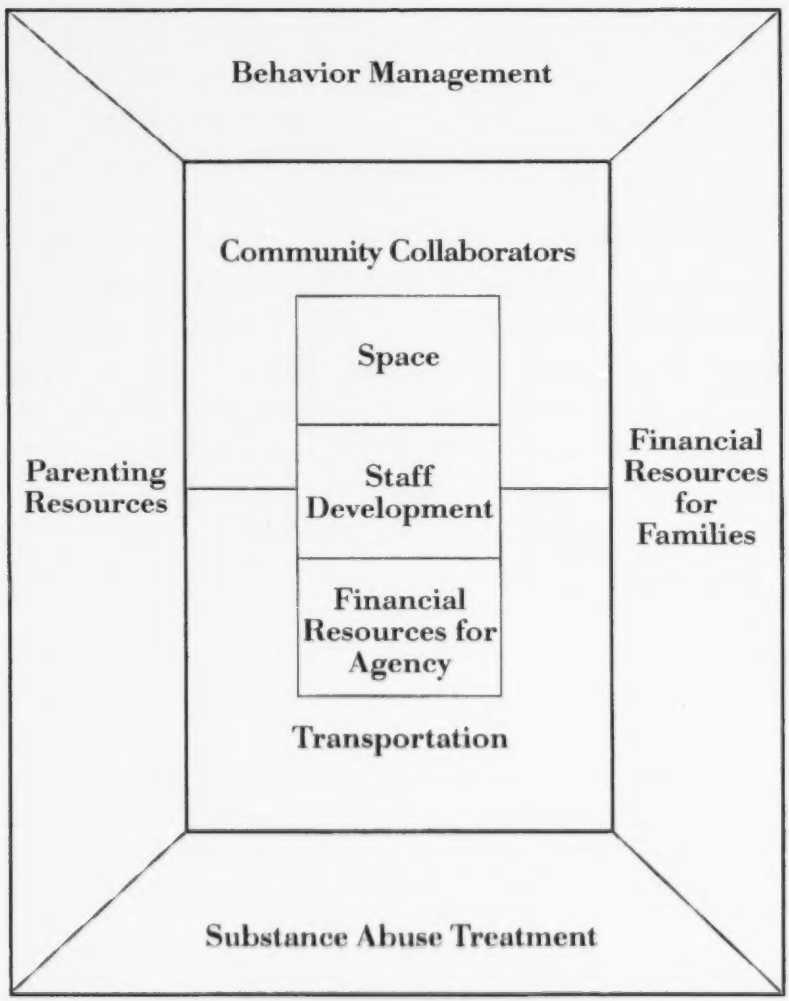


APPENDICES

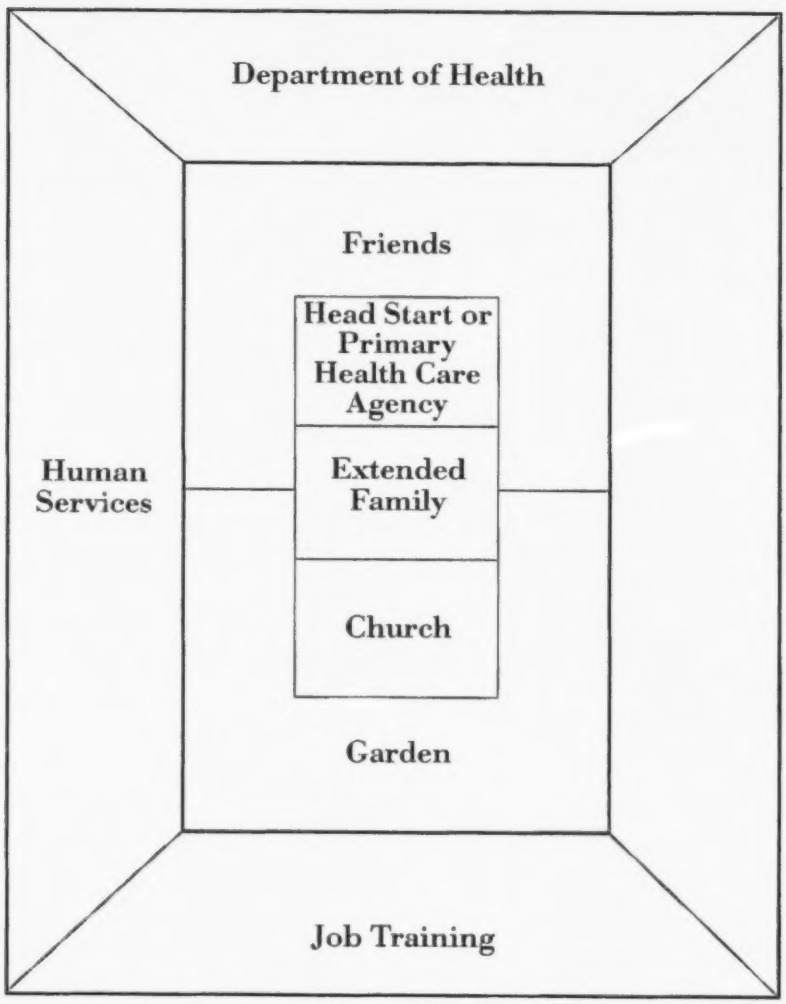
APPENDIX A.
SAMPLE FAMILY-NEEDS MAP



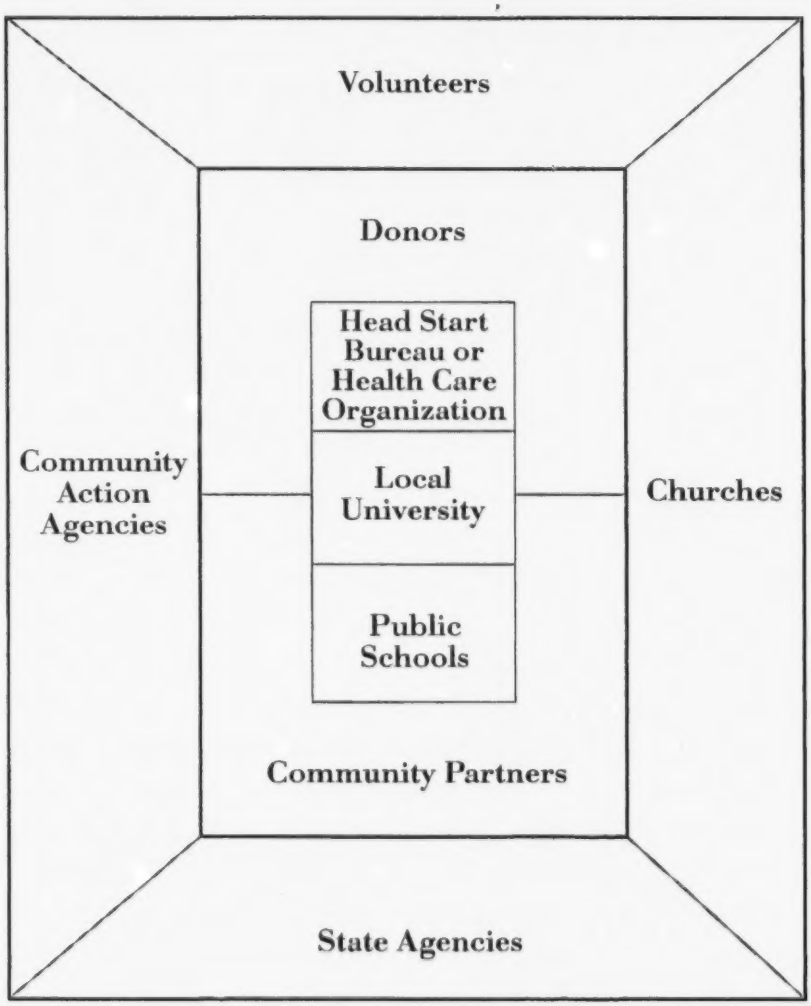
APPENDIX B.
SAMPLE AGENCY-NEEDS MAP



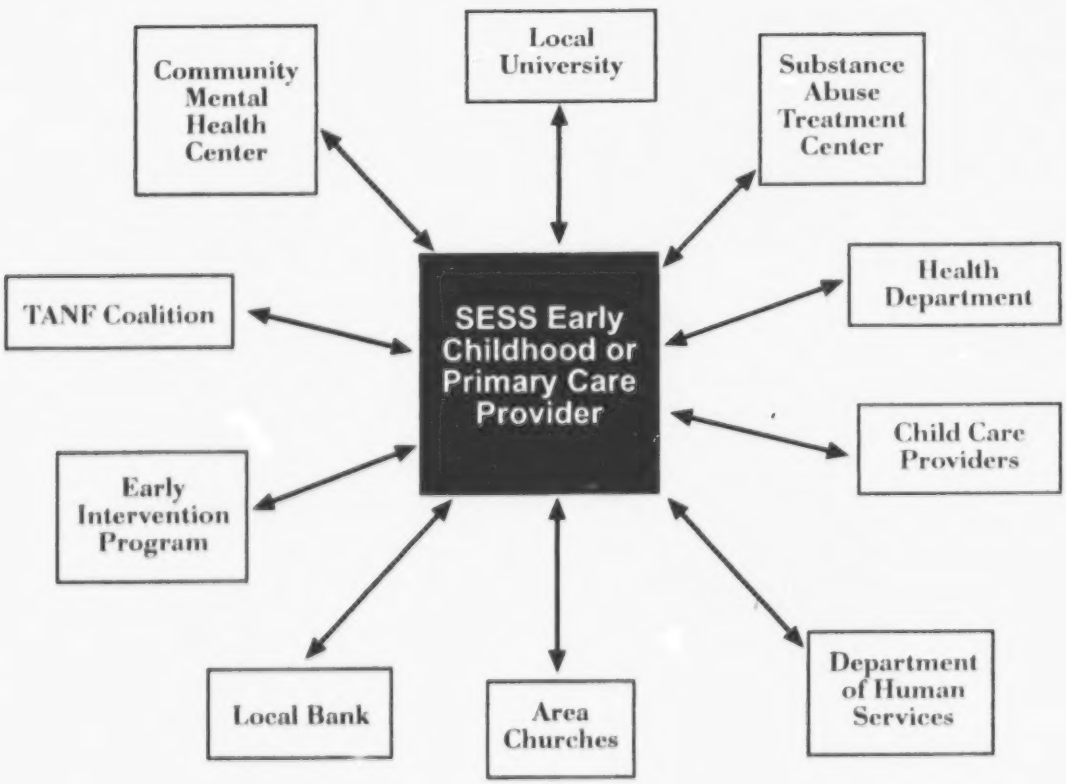
APPENDIX C.
SAMPLE FAMILY-ASSETS MAP



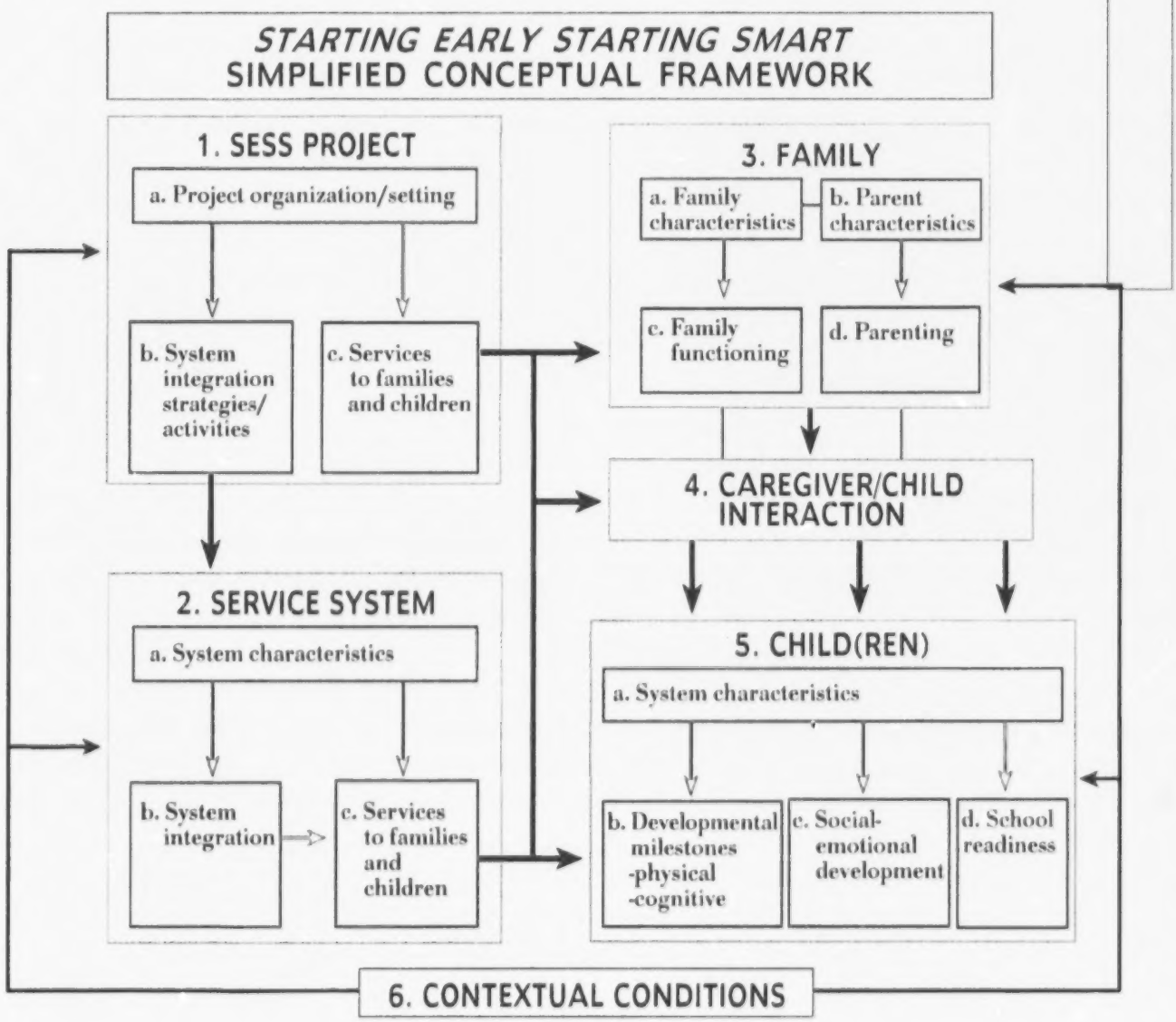
APPENDIX D.
SAMPLE AGENCY-ASSETS MAP



APPENDIX E.
Map of Potential SESS Partners



APPENDIX F.
SESS CONCEPTUAL MODEL OF CHANGE



APPENDIX G.
MISSION STATEMENTS OF THE SESS NATIONAL COLLABORATORS

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission within the Nation's health system is to improve the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness.

SAMHSA's mission is accomplished in partnership with all concerned with substance abuse and mental illness. SAMHSA exercises leadership in:

- eliminating the stigma that impedes prevention, treatment, and rehabilitation services for individuals with substance abuse;
- developing, synthesizing, and disseminating knowledge and information to improve prevention, treatment, rehabilitation services, and improving the organization, financing, and delivery of these services;
- providing strategic funding to increase the effectiveness and availability of services;
- promoting effective prevention, treatment, and rehabilitation policies and services;
- developing and promoting quality standards for service delivery;
- developing and promoting models and strategies for training and education;
- developing and promoting useful and efficient data collection and evaluation systems; and
- promoting public and private policies to finance prevention, treatment, and rehabilitation services so that they are available and accessible.

For more information visit SAMHSA's Web site at ***www.samhsa.gov***.

Casey Family Programs

The mission of Casey Family Programs is to support families, youth, and children in reaching their full potential. Casey provides an array of permanency planning, prevention and transition services such as long-term family foster care, adoption, kinship care, job training, and scholarships.

The Program aims to improve public and private services for children, youth, and families impacted by the child welfare system, through advocacy efforts, national and local community partnerships, and by serving as a center for information and learning about children in need of permanent family connections.

Casey Family Programs is a Seattle-based private operating foundation, established by Jim Casey, founder of United Parcel Services (UPS), in 1966. The program has 29 offices in 14 states and Washington, DC. For more information visit Casey's Web site at ***www.casey.org***.

APPENDIX H.
STARTING EARLY STARTING SMART GRANT SITES

Study Site	Principal Investigator	Project Director	Local Researcher	Phone Number
Data Coordinating Center				
EMT Associates, Inc. Folsom, CA	Joel Phillips	J. Fred Springer, Ph.D.	J. Fred Springer, Ph.D.	(615) 595-7658
Primary Care Site				
Boston Medical Center Boston, MA	Carolyn Seval, R.N., L.M.H.C.	Carolyn Seval, R.N., M.P.H., L.M.H.C.	Ruth Rose-Jacobs, Sc.D.	(617) 414-7433
The Casey Family Partners Spokane, WA	Christopher Blodgett, Ph.D.	Mary Ann Murphy, M.S.	Christopher Blodgett, Ph.D.	(509) 473-4810
University of Miami Miami, FL	Connie E. Morrow, Ph.D.	K. Lori Hanson, Ph.D.	Emmalee S. Bandstra, M.D. April L. Vogel, Ph.D.	(305) 243-2030
University of Missouri Columbia, MO	Carol J. Evans, Ph.D.	Robyn S. Boustead, M.P.A.	Carol J. Evans, Ph.D.	(573) 884-2029
University of New Mexico Albuquerque, NM	Andy Hsi, M.D., M.P.H.	Bebeann Bouchard, M.Ed.	Richard Boyle, Ph.D.	(505) 272-3469
Early Childhood Sites				
Asian American Recovery Services, Inc. San Francisco, CA	Davis Y. Ja, Ph.D.	Anne Morris, Ph.D.	Anne Morris, Ph.D.	(415) 541-9285 ext 227
Child Development, Inc. Russellville, AR	JoAnn Williams, M.Ed.	Carol Amundson Lee, M.A., L.P.C.	Mark C. Edwards, Ph.D.	(501) 968-6493
Children's National Medical Center Washington, DC	Jill G. Joseph, M.D., Ph.D.	Amy Lewin, Psy.D.	Michelle J.C. New, Ph.D.	(202) 884-3106
Johns Hopkins University Baltimore, MD	Philip J. Leaf, Ph.D.	Jocelyn Turner-Musa, Ph.D.	Philip J. Leaf, Ph.D.	(410) 955-3989
Division of Child and Family Services Las Vegas, NV	Christa R. Peterson, Ph.D.	Laurel L. Swetnam, M.A., M.S.	Margaret P. Freese, Ph.D., M.P.H.	(702) 486-6147
The Tulalip Tribes, Beda?chelh Marysville, WA	Linda L. Jones, B.A.	Linda L. Jones, B.A.	Claudia Long, Ph.D.	(360) 651-3282
The Women's Treatment Center Chicago, IL	Jewell Oates, Ph.D.	Dianne Stansberry, B.A., C.S.A.D.P.	Victor J. Bernstein, Ph.D.	(773) 373-8670 ext 3026

The SESS Sites

Miami's Families: Starting Early Starting Smart	Florida
Raising Infants in Secure Environments	Massachusetts
Healthy Foundations for Families	Missouri
Starting Early to Link Enhanced Comprehensive Treatment Teams	New Mexico
Casey Family Partners	Washington
National Association for Families and Addiction Research and Education	Illinois*
Child Development, Inc.	Arkansas
Asian American Recovery Services, Inc.	California
Locally Integrated Services in Head Start	Washington, D.C.
Starting Early Starting Smart Head Start Collaboration Project	Illinois
Baltimore BETTER Family and Community Partnership	Maryland
New Wish	Nevada
Beda?chelh Tulalip Tribes Early Intervention in Tribal and Mainstream Communities	Washington
Evaluation, Management and Training, Inc.**	California

*One of the original SESS sites was unable to continue with the study, but it was an important contributor to the original design and implementation of this project. Our thanks to Dr. Linda Randolph and Dr. Ira Chasnoff.

**Data Coordinating Center

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SAMHSA

CASEY FAMILY PROGRAMS
FOUNDATIONS FOR THE FUTURE

Healthy Minds, Healthy Behaviors: Promising Lives Right From the Start

CMHS

CSAT
Center for Substance Abuse Treatment
SAMHSA

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

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